BP-A0611 CDFRM
JUN 10

REQUEST FOR PURCHASE
PURCHASE CARD ACQUISITION (Not for Personal use Items)

Page 1 of 1

U.S. DEPARTMENT OF JUSTICE — **FEDERAL BUREAU OF PRISONS**

Institution/Facility	Requisitioning Department	Date of Order
MDC BROOKLYN	TRUST FUND	4/08/20

Requestor Name/Telephone Number: WAREHOUSE

Receiving Report # (Warehouse Use) _____

Warehouse Signature: _____

Item No.	GSA/Other Stock No.	DESCRIPTION	QTY	UNIT	UNIT PRICE	AMOUNT
		BAR SOAP	70	BX	$59.11	$ 4,137.70
						$ 0.00
						$ 0.00
						$ 0.00
						$ 0.00
						$ 0.00
						$ 0.00
						$ 0.00
						$ 0.00
						$ 0.00

Bureau of Prisons Tax ID: [redacted] **TOTAL AMOUNT** $ 4,137.70

Price Quotes	Item 1	Item 2	Item 3	Item 4	Item 1	Item 2	Item 3	Item 4	Item 1	Item 2	Item 3	Item 4
Source/Vendor Name	BOB BARKER											
Street												
City, State, Zip												
Contact Name/ Phone												

APPR	ACCOUNT CLASS (Accounting Code for purchase cards)	PROJ	SUB OBJECT	Date Required	Deliver To	Requested By
02	FP021453C1			4/15/20	WAREHOUSE	BALKARAN

Approving Official/Cost Center Manager: [signature] Date: 4/08/20

TO BE COMPLETED BY PROCUREMENT STAFF/CARDHOLDERS

Vendor/Address:	IG / PO NUMBER / CCR	
	Payment Terms	
Contact Name/Telephone/Fax	FOB (check one) ☐ Origin ☐ Destination	
Special Authorization APPROVED ☐	QUOTE SOURCE (check one) Telephone Catalog ☐ FSS ☐ Price List ☐ Internet ☐ IFB ☐ RFP ☐ RFQ No:	
TIN DUNS	YREGDOC# VC130039	RP#
SUPPLIES ONLY: Excess and rehabilitated sources have been screened and the property is not available from these sources.	CONTRACTING OFFICER	DATE
☐ WARNING! AMMUNITION/WEAPONS/HAZARDOUS MATERIAL FOR PENAL INSTITUTION – DELIVER TO ARMORY/SPECIFIED STAFF ONLY	CARDHOLDER (For Purchase Card acquisitions)	DATE

C 1 CC

Redacted

Order Acknowledgement

Order Number: NC1001528635
Order Date: 04/06/2020

Customer Code: [redacted]
Customer PO#: VC130039
Created By: kristynraftice
Ordered By: David Balkaran

BobBarker

Mailing: PO Box 429, Fuquay-Varina, NC 27526-0429
Payment: PO Box 890885, Charlotte, NC 28289-0885
Phones: [redacted] Fax: [redacted]
Fed I.D. #: [redacted]

Sold To:
FCI-Metro Detention Center

80 29th St
Brooklyn, NY 11232 US

Ship To:
FCI-Metro Detention Center
ATTN: David Balkaran
80 29th St
VC130039 - Trust Fund Super
Brooklyn, NY 11232 US

Product Code	Quantity	U/M	Unit Price	Amount
62107-C Soap, Bob Barker Wrapped #3 **Open Market Product**	70	C144	$59.11	$4,137.70

Subtotal:	4,137.70
Freight:	1,040.47
Taxes:	0.00
Payment:	0.00
Total: [redacted]	**$5,178.17**

Thank you for your order.. Your order will ship complete unless otherwise noted.

Visit [redacted] to track current orders and obtain order confirmations, invoice copies, and packing slips. Secure access credentials for your online account may be obtained by calling us at [redacted]

Orders and quote requests may be sent to [redacted]

Thank you again for your business.

Your Bob Barker Customer Service Team

VC130039

10,080

BAR Soap

C 1

CC

Redacted

Date: 04/08/2020
Time: 8:17:45 AM

Federal Bureau of Prisons
TRUTRAC

Facility: BRO

Purchase Order/Purchase Card Acquisition (Consolidated)
Sensitive But Unclassified

Institution / Facility	Requisitioning Department	Inventory Location	Date of Order
Brooklyn MDC		WAREHOUSE-MAIN	04/08/2020

Requestor Name / Telephone Number	Receiving Report # (Warehouse Use)
DAVID R BALKARAN / [redacted]	Warehouse Signature:

Comments:

Item Number	GSA/Other Stock No.	Description	QTY	UNIT	Unit Price	Amount
004		BAR SOAP, BX	70	EA	$59.11	$4,137.70
Bureau of Prisons Tax ID: [redacted]		TOTAL AMOUNT				$4,137.70

Price Quotes												
Source / Vendor Name												
Street												
City, State, Zip												
Contact Name / Phone												

APPR	ACCOUNT CLASS (Accounting Code for Purchase Cards)	PROJ	SUB OBJECT	Date Required	Deliver To	Requested By
	FP021453			04/08/2020		DAVID R BALKARAN
Approving Official / Cost Center Mgr					Date	

TO BE COMPLETED BY PROCUREMENT STAFF

Vendor / Address	IG	PO NUMBER	PO ID	DESG	RECYCLE	SAM
TRUE UNIFORM SUPPLY CO.	No	VC130039	[redacted]		No	
PO BOX 25874 - SCOTTSDALE, AZ 85255	Payment Terms			Ship Via		
SCOTTSDALE,, AZ 85255	FOB (check one)		Origin		Destination	
Contact Name / Telephone / Fax	QUOTE SOURCE (check one)			Telephone		Catalog
AARON TUCKER [redacted] (PH) / [redacted] (Fax)		Price List	Internet	IFB	RFP	
TIN\SSN	DUNS # [redacted]	RFQ	FSS	No:		
SUPPLIES ONLY: Excess and rehabilitated sources have been screened and the property is not available from these sources.	YREGDOC#			RP #		
	Contracting Officer / Cost Center Mgr			Date		
				4/8/20		
WARNING: AMMUNITION/WEAPONS/HAZARDOUS MATERIAL FOR PENAL INSTITUTIONS - DELIVER TO ARMORY/SPECIFIED STAFF ONLY	Cardholder (For Purchase Card Acquisition)			Date		
	SAM/EPLS Verified			Date		

User ID: TF43574

BOP 3

BP-A0611 CDFRM
JUN 10

REQUEST FOR PURCHASE
PURCHASE CARD ACQUISITION (Not for Personal use Items)

Page 1 of 1

U.S. DEPARTMENT OF JUSTICE — **FEDERAL BUREAU OF PRISONS**

Institution/Facility	Requisitioning Department	Date of Order
EDC BROOKLYN	Safety	September 27, 2019

Requestor Name/Telephone Number	Receiving Report # (Warehouse Use) / Warehouse Signature:
Andrew L. Butler, ESCA	

Item No.	GSA/Other Stock No.	DESCRIPTION	QTY	UNIT	UNIT PRICE	AMOUNT
1	Goj911212ct	GOJO Hand Soap	83	EA	$47.54	$ 3,945.82
2						$ 0.00
3						$ 0.00
4						$ 0.00
5						$ 0.00
6						$ 0.00
						$ 0.00
						$ 0.00
						$ 0.00
						$ 0.00

Bureau of Prisons Tax ID: [redacted] **TOTAL AMOUNT** $ 3,945.82

Price Quotes	Item 1	Item 2	Item 3	Item 4	Item 1	Item 2	Item 3	Item 4	Item 1	Item 2	Item 3	Item 4
Source/Vendor Name	Shoplet											
Street												
City, State, Zip												
Contact Name/ Phone	[redacted]											

APPR	ACCOUNT CLASS (Accounting Code for purchase cards)	PROJ	SUB OBJECT	Date Required	Deliver To	Requested By
				September 27, 2019	Safety	

Approving Official/Cost Center Manager: AL — Date: 9/27/19

TO BE COMPLETED BY PROCUREMENT STAFF/CARDHOLDERS

Vendor/Address:	IG	PO NUMBER	CCR
		Conf. 1569549761	
	Payment Terms: NA		
	FOB (check one) ☐ Origin ☐ Destination		
Contact Name/Telephone/Fax	QUOTE SOURCE (check one) ☐ Price List ☐ Internet ☐ Telephone ☐ IFB ☐ Catalog ☐ RFP ☐ FSS ☐ RFQ No:		
IN DUNS Sam Verified	YREGDOC# UB300013	RP#	
SUPPLIES ONLY: Excess and rehabilitated sources have been screened and the property is not available from these sources.	CONTRACTING OFFICER	DATE	
☐ WARNING! AMMUNITION/WEAPONS/HAZARDOUS MATERIAL FOR PENAL INSTITUTION - DELIVER TO ARMORY/SPECIFIED STAFF ONLY	CARDHOLDER (For Purchase Card acquisitions)	DATE	

Redacted

shoplet

Invoice

Shoplet.com
39 Broadway
Suite 2030
New York, NY 10006

Tel [redacted]
Fax
Toll-Free

Order Placed	Order Number
09/27/2019	1569599761

Bill To

Tristan Rohlfs
MDC Brooklyn
80-29TH ST
Brooklyn, NY 11232
United States

Ship To

Safety Department
MDC Brooklyn
80-29TH ST
Brooklyn, NY 11232
United States

Quantity	Item No.	Description	Price	Total
83	GOJ911212CT	Lotion Skin Cleanser Refill	$47.54	$3,945.82

Subtotal	**$3,945.82**
Tax	**$0.00**
Shipping	**$0.00**
Total	**$3,945.82**
Paid	**$3,945.82**

BP-A0611 CDFRM
JUN 10

REQUEST FOR PURCHASE
PURCHASE CARD ACQUISITION (Not for Personal use Items)

Page 1 of 1

U.S. DEPARTMENT OF JUSTICE — **FEDERAL BUREAU OF PRISONS**

Institution/Facility	Requisitioning Department	Date of Order
MDC BROOKLYN	TRUST FUND	10/12/19

Requestor Name/Telephone Number: WAREHOUSE

Receiving Report # (Warehouse Use): 20TT031

Warehouse Signature:

Item No.	GSA/Other Stock No.	DESCRIPTION	QTY	UNIT	UNIT PRICE	AMOUNT
		BAR SOAP	216	BX	$80.44	$ 17,375.04
					$17.15	$ 0.00
					$17.15	$ 0.00
					$25.75	$ 0.00
					$25.75	$ 0.00
					$7.85	$ 0.00
					$15.75	$ 0.00
					$3.50	$ 0.00
					$42.00	$ 0.00
					$13.25	$ 0.00

Rec'd 01-30-20

Bureau of Prisons Tax ID: [redacted]

TOTAL AMOUNT $ 17,375.04

Price Quotes	Item 1	Item 2	Item 3	Item 4	Item 1	Item 2	Item 3	Item 4	Item 1	Item 2	Item 3	Item 4
Source/Vendor Name	GSA ADVANTAGE											
Street												
City, State, Zip												
Contact Name/ Phone												

APPR	ACCOUNT CLASS (Accounting Code for purchase cards)	PROJ	SUB OBJECT	Date Required	Deliver To	Requested By
02	FP021453C1			10/12/19	WAREHOUSE	BALKARAN

Approving Official/Cost Center Manager

Date: 10/12/19

TO BE COMPLETED BY PROCUREMENT STAFF/CARDHOLDERS

Vendor/Address:	IG	PO NUMBER	CCR
	Payment Terms		
Contact Name/Telephone/Fax	FOB (check one) ☐ Origin ☐ Destination		
Special Authorization APPROVED ☐	QUOTE SOURCE (check one) ☐ Price List No: ☐ Internet ☐ IFB ☐ RFP ☐ RFQ Telephone ☐ Catalog ☐ FSS		
TIN DUNS	YREGDOC#	RP#	
SUPPLIES ONLY: Excess and rehabilitated sources have been screened and the property is not available from these sources.	CONTRACTING OFFICER	DATE	
☐ WARNING! AMMUNITION/WEAPONS/HAZARDOUS MATERIAL FOR PENAL INSTITUTION - DELIVER TO ARMORY/SPECIFIED STAFF ONLY	CARDHOLDER (For Purchase Card acquisitions)	DATE	

Da 01/30/2020
Time: 10:48:27 AM

Federal Bureau of Prisons
TRUTRAC
Receiving Report
Sensitive But Unclassified

Facility: BRO

Receiver# : 20TT0031

(Consolidated)

COMPLETE ORDER
GSA ADVANTAGE
2100 CRYSTAL DIVE
ARLINGTON,Virginia 22202

PURCHASE ORDER NO: VC130003
PO ENTER DATE: 10/11/2019
EXPECTED RECEIVE DATE: 10/14/2019

RECEIVING REPORT NO: 20TT0031
ACTUAL RECEIVE DATE: 01/30/2020
USER ID: TF14716

Item#/UPC	Item Description	Qty Ord	Qty Rec	Qty BO	Cost Per Item	Total Cost
004	BAR SOAP, BX	216	216	0	$80.4400	$17,375.04

Total Line Items (1)
Credit Card = No

Total Cost:	$17,375.04
Shipping/Tax:	$0.00
Grand Total:	**$17,375.04**
PO Amount:	**$24,132.00**
Received To-Date Amount:	**$26,866.96**

Comments: LATE INVENTORY LOADING DUE TO AMENDMENT AS PER CHANGE IN CASE QTY, REFER TO ATTCHED MEMO. DUE TO VARIOUS CARRIERS NO PACKING SLIP WAS ATTACHED OR RECEIVED.

Received by

User ID: [redacted]

BOP 7

U.S. Department of Justice
Federal Bureau of Prisons

P R O G R A M S T A T E M E N T
OPI: CPD/CPB
NUMBER: 6190.04
DATE: June 3, 2014

Infectious Disease Management

/s/
Approved: Charles E. Samuels, Jr.
Director, Federal Bureau of Prisons

1. **PURPOSE AND SCOPE**

§ 549.11 Purpose and scope.

The Bureau will manage infectious diseases in the confined environment of a correctional setting through a comprehensive approach which includes testing, appropriate treatment, prevention, education, and infection control measures.

2. **SUMMARY OF CHANGES**

Policy Rescinded
P6190.03 Infectious Disease Management (6/28/05)

Section 7.a.5 replaces existing language with the following:

The institution's A&O program meets the HIV pre-test counseling requirement if documentation such as a sign-in roster is obtained and kept on file. Inmates are not required to sign an informed consent form during HIV counseling sessions. When the pre-test counseling is completed, HSD requires risk-based HIV testing per policy, but recommends testing all sentenced inmates unless they choose to opt out of HIV testing.

Federal Regulations from 28 CFR are shown in this type.
Implementing instructions are shown in this type.

Transporting officials will only accept an inmate who has a health record review documenting no evidence of medical complaints/symptoms associated with TB within the past 30 days and has one of the following screening criteria prior to transport:

- A valid negative tuberculin skin test documented in millimeters within the past 12 months.
- A negative chest x-ray result if the tuberculin skin test is positive or the tuberculin skin test is medically contraindicated.

There is no longer a need to have an annual chest x-ray as long as a baseline chest x-ray is documented.

Findings of the evaluation/examination in BOP contract facilities not using BEMR should be documented in the "Additional Information" section of the Medical Summary of Federal Prisoner/Alien in Transit (BP-A0659), if symptoms are present.

Findings of the evaluation/examination in BOP institutions and BOP contract facilities using BEMR should be documented under "Comments" in the BEMR Exit Summary for Inmate Intra-system Transfer, if symptoms are present.

One of the above criteria must be documented on the Medical Summary of Federal Prisoner/Alien in Transit (BP-A0659) at BOP contract facilities not using BEMR or on the BEMR Exit Summary for Inmate Intra-system Transfer at BOP institutions and BOP contract facilities using BEMR.

3. **PROGRAM OBJECTIVES**

The expected results of this Program Statement are:

- The incidence and associated health risks of infectious diseases will be reduced.
- Inmates will receive appropriate training, education, and counseling on contagious disease prevention.
- Risks of infection will be reduced by universal precautions, engineering and work practice controls, appropriate treatment, use of vaccinations, use of personal protective equipment, and other infection control measures.
- Occupational Safety and Health Administration (OSHA) standards relevant to infectious disease management will be met.
- Compliance with the "Correction Officers Health and Safety Act of 1998" will be attained.

4. DIRECTIVES AFFECTED

Program Statements

P1351.05	Release of Information (9/19/02)
P1600.09	Occupational Safety, Environmental Compliance, and Fire Protection (10/31/07)
P5050.49	Compassionate Release/Reduction in Sentence (8/12/13)
P5214.04	HIV Positive Inmate Who Pose Danger to Other, Procedures for Handling of (2/4/98)
P5270.09	Inmate Discipline Program (7/8/11)
P5290.14	Admission and Orientation Program (4/3/03)
P5500.14	Correctional Services Procedures Manual (10/19/12)
P5538.05	Escorted Trips (10/6/08)
P5566.06	Use of Force and Applications of Restraints (10/30/05)
P6031.04	Patient Care (6/3/14)
P6090.03	Health Information Management (7/31/12)

Rules cited in this Program Statement are contained in 28 CFR 549.10 through 549.15.

Rules referenced in this Program Statement are contained in 5 CFR 339.102 and 339.301 through 339.305 and 29 CFR § 1910.1030 (Bloodborne Pathogens).

"Correction Officers Health and Safety Act of 1998", Pub. L. 105-370, November 12, 1998, 112 Stat. 3374, Sec. 2. Testing for Human Immunodeficiency Virus.

5. STANDARDS REFERENCED

- American Correctional Association Standards for Adult Correctional Institutions, 4th Edition: 4-4281, 4-4354, 4-4355, 4-4356, 4-4357, and 4-4358.
- American Correctional Association 4th Edition Performance Based Standards for Adult Local Detention Facilities, 4th Edition: 4-ALDF-4C-08; 4-ALDF-4C-15; 4-ALDF-4C-16; 4-ALDF-4C-17; 4-ALDF-4C-18.
- American Correctional Association Standards for the Administration of Correctional Agencies, 2nd Edition: 2-CO-4E-01.

6. **PROGRAM RESPONSIBILITY**

§ 549.11 Program responsibility.

Each institution's Health Services Administrator (HSA) and Clinical Director (CD) are responsible for the operation of the institution's infectious disease program in accordance with applicable laws and regulations.

a. The HSA will provide:

- Infectious disease procedures written in accordance with this Program Statement and other Bureau policy.
- Infectious disease procedures that incorporate and reference, as applicable, standards, guidelines, and recommendations from other Federal agencies including the Department of Health and Human Services (HHS), the Centers for Disease Control and Prevention (CDC), the Occupational Safety and Health Administration (OSHA), and the National Institutes for Occupational Health (NIOSH). Applicable standards and guidelines will be provided to the Infection Control Officer (ICO).
- An institution occupational exposure control plan for bloodborne pathogens and tuberculosis (TB) in accordance with applicable OSHA Standards.
- The CDC Morbidity and Mortality Weekly Report (MMWR) is available to institution clinical staff for review either as hard copy or on-line.
- A Registered Nurse (RN) or Mid-Level Practitioner (MLP) will be designated, through attrition, as the institution ICO. He/she is responsible for implementing the institution infection control program. The responsibilities of the designated person will be defined in writing (refer to the Quality Improvement/ Infection Control Officer position description).
- Infectious disease procedures will be reviewed annually by the HSA and CD to ensure clinical accuracy.
- The CD, HSA, ICO, and other appropriate institution staff will meet at least quarterly to review the implementation of the institution's infection control and surveillance program.
- Evidence of, at a minimum, quarterly Infection Control meetings (minutes) and review of surveillance activities that are documented and included as part of the institution's Quality Improvement Program (QIP).

7. **TESTING**

§ 549.12 Testing.

All HIV testing will be conducted using a Food and Drug Administration (FDA)-approved method. All HIV testing requires pre- and post-test counseling. Classification of HIV testing includes:

- **Voluntary**. Voluntary testing is done when the inmate requests testing via an Inmate Request to Staff Member (BP-A0148) form, which will be turned into Health Services.
- **Mandatory**. Mandatory testing is performed when there are risk factors and the test is clinically indicated and/or surveillance testing is required. Inmates must participate in mandatory HIV testing programs. If an inmate refuses mandatory testing, staff will initiate an incident report for failure to follow an order. Inmate written consent is not required.
- **Involuntary Testing**. Involuntary testing is performed following an exposure incident. Written consent of the inmate is not required. If an inmate refuses testing, testing will be conducted in accordance with the Program Statement on Use of Force.

a. Human Immunodeficiency Virus (HIV)

(1) Clinically Indicated. The Bureau tests inmates who have sentences of six months or more if health services staff determine, taking into consideration the risk as defined by the Centers for Disease Control guidelines, that the inmate is at risk for HIV infection. If the inmate refuses testing, staff may initiate an incident report for refusing to obey an order.

Inmates housed in BOP institutions, regardless of commitment status, who have risk factors for HIV infection or clinical evidence of HIV infection, will be tested in accordance with clinical guidance from the Medical Director.

(2) Exposure Incidents. The Bureau tests an inmate, regardless of the length of sentence or pretrial status, when there is a well-founded reason to believe that the inmate may have transmitted the HIV infection, whether intentionally or unintentionally, to Bureau employees or other non-inmates who are lawfully present in a Bureau institution. Exposure incident testing does not require the inmate's consent.

An exposure incident means a specific eye, mouth, other mucous membrane, non-intact skin, or parenteral contact with blood or other potentially infectious body fluids.

Inmates involved in an exposure incident will be tested for HIV infection. If an inmate refuses, institution medical staff will test the inmate involuntarily with authorization from the Warden. A court order is not required.

The Warden, or designee, will determine whether inmates who are subject to an incident report for failure to obey an order are placed in administrative detention/segregation.

After the inmate is involuntarily tested for HIV, the CD will send a message to the Bureau Medical Director with a copy to the Regional Director. The message must contain:

- The inmate's name and register number.
- The specific diagnosis.
- A description of the exposure incident.
- An indication that education and counseling have been provided to the inmate prior to testing.

(3) Surveillance Testing. The Bureau conducts HIV testing for surveillance purposes as needed. If the inmate refuses testing, staff may initiate an incident report for refusing to obey an order.

Surveillance testing may include but is not limited to testing of newly incarcerated inmates with serial retesting or a random sampling of institutional populations. This testing is conducted based upon guidance from the Medical Director.

(4) Inmate Request. An inmate may request to be tested. The Bureau limits such testing to no more than one per 12-month period unless the Bureau determines that additional testing is warranted.

HIV testing that is requested by an inmate is considered voluntary testing.

(5) Counseling. Inmates being tested for HIV will receive pre and post-test counseling, regardless of the test results.

Medical staff will provide HIV counseling to inmates in accordance with guidance from the Medical Director and CDC recommendations. Counseling will be provided in a language that is easily understood by the inmate.

Individual and confidential pre-test (unless random) and post-test counseling will be the institution physician's responsibility; however, any appropriately trained health care provider

may conduct the actual counseling. The physician or the ICO will counsel all post-test inconclusive inmates. The physician will counsel all post-test positive inmates.

Pre and post-test counseling will address the limitations of the test, i.e., the inability to detect early infections, false positives, false negatives, and the possible need for additional testing as well as the complications and consequences of a negative or positive test result.

Pregnant inmates who test positive will be advised the virus may be transmitted to the fetus and of current treatment options to prevent perinatal transmission.

All inmates testing positive will be referred to the Psychology Department for follow-up counseling.

The institution's A&O program meets the HIV pre-test counseling requirement if documentation such as a sign-in roster is obtained and kept on file. Inmates are not required to sign an informed consent form during HIV counseling sessions. When the pre-test counseling is completed, HSD requires risk-based HIV testing per policy, but recommends testing all sentenced inmates unless they choose to opt out of HIV testing.

The HIV Post-Test Counseling forms BP-A0491 and BP-A0492 will be used for post-test counseling documentation. The forms will be signed by the inmate and retained in the medical record. All forms are available on Sallyport.

b. Tuberculosis (TB)

(1) The Bureau screens each inmate for TB within two calendar days of initial incarceration.

Contagious pulmonary TB disease must be eliminated as a potential diagnosis prior to placing an inmate into general population. Screening for active TB disease for newly incarcerated inmates includes the following:

All inmates will be assessed by a health care professional for clinical signs and symptoms (i.e., weight loss, chronic cough, hemoptysis) of active pulmonary TB during intake screening. The clinical assessment must be documented in the health record. All inmates with symptoms of pulmonary TB will be further evaluated with a chest radiograph.

Tuberculin skin test screening with the PPD (purified protein derivative) skin test, must be initiated within two calendar days of initial incarceration to screen for both latent TB infection and TB disease unless a previously positive tuberculin skin test has been adequately documented.

It is recommended that the TB skin test be placed during intake screening. Inmates with a documented previously positive tuberculin skin test, should not be retested, but should be screened for active TB disease by chest radiograph.

A self-reported, undocumented previous positive tuberculin skin test is not a contraindication to receiving a tuberculin skin test unless a severe previous reaction (e.g. whole arm swelling or severe blistering) has been documented or described by the inmate.

Asymptomatic inmates with a positive tuberculin skin test at intake, or a previously positive tuberculin skin test, will have a chest radiograph completed within 14 calendar days to screen for TB disease unless the inmate has a documented negative chest x-ray subsequent to the positive skin test.

An inmate may not request to substitute a chest radiograph for a screening tuberculin skin test. The only exception is when there is a medical contraindication to tuberculin skin testing or in instances where involuntary testing may cause significant injury to the staff or inmate. The CD or designee is the approving authority for ordering a screening chest radiograph in lieu of an otherwise indicated tuberculin skin test.

Refer to Subsection (4) below for information on inmates who refuse PPD skin testing.

Inmates will be evaluated and treated for latent TB infection or TB disease in accordance with guidance from the Medical Director.

(2) The Bureau conducts screening for each inmate annually as medically indicated.

All inmates without prior TB infection must be screened annually for newly acquired TB infection, including the following:

- An evaluation by a health care professional for signs and symptoms of TB disease.
- An annual tuberculin skin test for all inmates with a prior negative tuberculin skin test who have no medical contraindications for testing.
- A chest x-ray for all inmates with a newly positive annual tuberculin skin test will be completed within 14 calendar days of the annual tuberculin skin test, or sooner if the inmate has symptoms of TB disease. If the inmate is symptomatic, immediately obtain a chest radiograph and place the inmate in a negative pressure isolation room (NPIR) or make arrangements to transport the inmate to the community hospital.

- An inmate may not request to substitute a chest radiograph for an annual tuberculin skin test. The only exception is when there is a medical contraindication to tuberculin testing or in instances where involuntary testing may cause significant injury to the staff or inmate. The CD or designee is the approving authority for ordering a screening chest radiograph in lieu of an otherwise indicated tuberculin skin test.

(3) The Bureau will screen an inmate for TB when health services staff determine that the inmate may be at risk for infection.

Inmates who have clinical evidence of active TB or a recent exposure to TB will be evaluated in accordance with guidance from the Medical Director.

(4) An inmate who refuses TB screening may be subject to an incident report for refusing to obey an order. If an inmate refuses skin testing, and there is no contraindication to tuberculin skin testing, then, institution medical staff will test the inmate involuntarily.

The physician will document the education and counseling as well as the specific diagnostic evaluation or procedure in the inmate's health record.

Inmates who refuse TB screening will not be placed in medical isolation unless there is a clinical indication for such isolation.

For tracking purposes, after involuntary tuberculin testing for TB infection, the CD will send a message to the Bureau Medical Director with a copy to the respective Regional Director. The message must contain:

- The inmate’s name and register number.
- The specific diagnosis.
- A description of the exposure incident.
- Some indication that education and counseling have been provided to the inmate.

(5) The Bureau conducts TB contact investigations following any incident in which inmates or staff may have been exposed to tuberculosis. Inmates will be tested according to paragraph (b)(4) of this section. (For WITSEC inmates, refer to Section 10.)

All active pulmonary TB cases will be investigated when indicated according to CDC guidelines. The investigation and evaluation will be conducted in consultation with the local health

department and Regional and Central Office administrative staff (see Section 8. for surveillance reporting).

(6) **Refusal of Treatment**. Refer to the Program Statement **Patient Care**, Involuntary Medical Treatment/Refusal of Treatment when an inmate refuses treatment for active tuberculosis disease and the inmate poses a risk to others by refusing treatment.

(7) **Medical Clearance for Transporting Inmates**. BOP inmates (including all holdover status inmates; i.e., DEA, U.S. Marshals Service, Bureau of Immigration and Customs Enforcement (ICE), FBI, etc.) who have not been screened for TB are prohibited from transfer between Bureau institutions. Transporting officials will only accept any inmate who has a health record review documenting no evidence of medical complaints/symptoms associated with TB within the past 30 days and has one of the following screening criteria prior to transport:

- A valid negative tuberculin skin test documented in millimeters within the past 12 months.
- A baseline negative chest x-ray result if the tuberculin skin test is positive or the tuberculin skin test is medically contraindicated.

There is no longer a need to have an annual chest x-ray as long as a baseline chest x-ray is documented.

Inmates who have been evaluated for symptoms such as a cough or chills within the past 30 days will be evaluated prior to transport, as clinically indicated.

Findings of the evaluation/examination in BOP contract facilities not using BEMR should be documented in the "Additional Information" section of the BP-A0659, if symptoms are present.

Findings of the evaluation/examination in BOP institutions and BOP contract facilities using BEMR should be documented under "Comments" in the BEMR Exit Summary for Inmate Intra-system Transfer, if symptoms are present.

One of the above criteria must be documented on the Medical Summary of Federal Prisoner/Alien in Transit (BP-A0659) at BOP contract facilities not using BEMR or on the BEMR Exit Summary for Inmate Intra-system Transfer at BOP institutions and BOP contract facilities using BEMR.

For security reasons, the CD may recommend the requirement for a tuberculin skin test or chest x-ray be waived prior to the immediate transport of an inmate, (e.g., an uncooperative inmate where the risk of injury to the inmate or staff precludes involuntary forced testing). An institution physician will examine and clear such inmates for transfer and document this

recommendation. If the tuberculin skin test or chest x-ray is waived, the inmate will be tested upon arrival at the receiving institution.

c. Diagnostics. The Bureau tests an inmate for an infectious or communicable disease when the test is necessary to verify transmission following exposure to bloodborne pathogens or to infectious body fluid. An inmate who refuses diagnostic testing is subject to an incident report for refusing to obey an order.

Testing for viral hepatitis, sexually transmitted infections (STI) and other infectious diseases will be performed based upon clinical indications and guidance from the Medical Director.

d. **Disease Prevention**. Influenza, Pneumococcal, Tetanus/Diphtheria, and Measles/Mumps/Rubella immunizations will be provided routinely to inmates in accordance with CDC guidelines and guidance from the Medical Director.

All inmates who receive vaccinations will be provided information, based on the Center for Disease Control and Prevention (CDC) Vaccine Information Statements (VIS), about the risks and benefits of the vaccine including specific side effects that may occur.

Informed consents are recommended in accordance with State laws.

Health Services staff will maintain the immunization record in each inmate's health record.

8. **MONITORING, BUREAU REPORTING, AND SURVEILLANCE**

All Bureau reportable infectious diseases are identified on the Sensitive Medical Data (SMD) Outpatient Morbidity and Procedures Classification Reporting. Each institution will ensure that all cases of infectious diseases are entered into the SENTRY SMD system consistent with current policy. The ICO will monitor prevalence and incidence data by retrieving data from the SENTRY SMD system or other tracking mechanism.

The ICO will ensure that infectious disease outbreaks or infectious diseases with outbreak potential are reported to the Health Services Division, Central Office, on the Infectious Disease Outbreak Record form (BP-A0664).

The ICO will ensure all active TB cases are reported to the Health Services Division, Central Office, on the Tuberculosis Case/Suspect Record and Referral form (BP-A0665), if a state reporting form is not available for submission.

Consultation on specific TB control, evaluation measures, and treatment will be provided to the institution CD.

The Central Office will be notified of all investigation outcomes, i.e.:

- Number of inmates and number of staff screened.
- The number of exposures (or conversions)for each group (inmates and staff).
- The number(s) treated.

9. **PROGRAMMING, DUTY, AND HOUSING RESTRICTIONS**

§ 549.13 Programming, duty, and housing restrictions.

a. The CD will assess any inmate with an infectious disease for appropriateness for programming, duty, and housing. Inmates with infectious diseases that are transmitted through casual contact will be prohibited from work assignments in any area, until fully evaluated by a health care provider.

b. Inmates may be limited in programming, duty, and housing when their infectious disease is transmitted through casual contact. The Warden, in consultation with the CD, may exclude inmates, on a case-by-case basis, from work assignments based upon the security and good order of the institution.

Inmates with infectious diseases that are not foodborne or transmitted by casual contact; i.e., HBV, HCV, HIV, are not prohibited from assignment to Food Service based solely upon the diagnosis of the infectious disease. The primary care provider will determine the inmate's suitability for Food Service.

c. If an inmate tests positive for an infectious disease, that test alone does not constitute sole grounds for disciplinary action. Disciplinary action may be considered when coupled with a secondary action that could lead to transmission of an infectious agent. Inmates testing positive for infectious disease are subject to the same disciplinary policy that applies to all inmates (see 28 CFR 541, subpart B). Except as provided for in our disciplinary policy, no special or separate housing units may be established for HIV-positive inmates.

In addition to standard precautions, all institutions will utilize appropriate transmission-based **precautions**, such as:

- Airborne precautions for small particle organisms.

- Droplet precautions for large particle organisms.
- Contact precautions for direct skin-to-skin touching or when indirect spread may occur.

Necessary containment measures will be used to transport, isolate, restrict contact of inmates with potentially communicable disease, until no longer contagious.

Only those institutions equipped with the proper engineering controls to house inmates in a negative pressure isolation room (NPIR) that comply with the current CDC recommendations, have the option to isolate and treat inmates with suspected TB or other airborne disease (requiring airborne precautions) that may remain suspended in the air and be spread by casual contact.

Refer to Section 11, for NPIR controls under engineering controls and personal protective equipment (PPE). Otherwise, arrangements will be made to transport the inmate to the local hospital with the necessary facilities to isolate and treat until the inmate is no longer contagious.

(1) **Containment** will include the following:

- Until the inmate is transported to a local hospital, he or she will be immediately removed from the institution's general population.
- The inmate will be placed in a low traffic flow area until transported to a local hospital.
- When transporting the inmate in a vehicle or when interacting with the inmate in a negative pressure room, special respirator precautions will be taken.
- Escort personnel will wear an appropriately fitted NIOSH-certified Respirator (N95 efficiency or better) whenever interacting with the inmate in a room or closed environment.
- The inmate is to be moved from the holding area to R&D in a manner to eliminate or minimize contact with other staff or inmates. The inmate will be issued and wear a standard "surgical-type" mask.
- No other inmates will be transported with an inmate suspected of or diagnosed with a contagious communicable disease.

(2) **Appearances at Court, ICE, or U.S. Parole Commission (USPC) Hearings**. If for any reason an inmate with suspected TB or other communicable contagious disease is scheduled to appear in Court, before an Executive Office of Immigration Review (EOIR) judge or Cuban Review Panel, an ICE or USPC hearing, the Warden will ensure the appropriate hearing authority is notified that the inmate is undergoing treatment for a communicable contagious disease and cannot be moved until the treating physician determines that the inmate is considered no longer contagious.

If possible, a tentative treatment timetable and date of inmate availability should be given to the hearing authority.

(3) **Staff Escorting Inmates with TB, Suspected TB or Other Communicable Contagious Diseases**. Special respiratory protection measures will be taken when transporting the inmate in a vehicle or when interacting with the inmate in a negative pressure room.

Escort personnel, including contract guard services, clinical staff, and others in close contact with the inmate will wear a NIOSH approved respirator (N-95 or better).

Prior to use of a respirator, staff will be medically cleared, fit-tested and trained in accordance with the current OSHA standard on respiratory protection.

10. **CONFIDENTIALITY OF INFORMATION**

§ 549.14. Confidentiality of information.

Any disclosure of test results or medical information is made in accordance with:

a. The Privacy Act of 1974, under which the Bureau publishes routine uses of such information in the Department of Justice Privacy Act System of Records Notice entitled "Inmate Physical and Mental Health Record System, JUSTICE/BOP-007"; and

b. The Correction Officers Health and Safety Act of 1998 (codified at 18 U.S.C. § 4014), which provides that test results must be communicated to a person requesting the test, the person tested, and, if the results of the test indicate the presence of HIV, to correctional facility personnel consistent with Bureau policy.

Relevant infectious disease data will be disclosed as follows:

(1) To State Health Departments and/or the Center for Disease Control, pursuant to state and/or federal laws requiring notice of cases of reportable infectious diseases;

If the inmate is a WITSEC, and circumstances mandate that an infectious disease be reported to the Public Health Department (county or state), Inmate Monitoring, Central Office, must be notified prior to any release of the inmate's name and/or any communication (telephone, face-to-face, etc.) between the inmate and public health officials.

The HSA or designee will ensure that the respective State Health Department is informed of all cases of reportable infectious disease.

(2) Findings of all contact investigations will be reported, as required, to the State Health Department.

(3) The Community Corrections Manager will receive a copy of the Medical/Psychological Pre-Release Evaluation form (BP-A0351), included in the request for CCC placement. This form will identify inmates known to be HIV positive, or under treatment for exposure to, or active TB.

(4) To the physician/provider of a Bureau or non-Bureau staff, or other person exposed to a bloodborne pathogen while lawfully present in a Bureau facility, for the purpose of providing prophylaxis or other treatment and counseling;

(5) To Department of Justice employees who have a need to know in the performance of their duties including, but not limited to, Health Care Personnel, Social Workers, Unit Management staff, and Psychologists.

(6) All parties, with whom confidential medical information regarding another individual is communicated, will be advised not to share this information, by any means, with any other person. Medical information may be communicated among medical staff directly concerned with an inmate's case in the course of their professional duties.

11. **EXPOSURE CONTROL PLAN**

Each institution will have a written Exposure Control Plan (ECP) that will comply with and contain the elements as defined in 29 CFR 1910.1030, Bloodborne Pathogens. Staff will be trained on compliance with 29 CFR 1910.1030 on employment and during annual training.

a. **Exposure Determination**. All Bureau employees assigned to correctional facilities are required to perform tasks which potentially could expose them to blood and body substances. All Bureau employees are covered by, and must comply with, all aspects of the ECP.

Each institution will identify in the ECP the classification of work assignments for inmates based upon risk of occupational exposure.

b. **Methods of Compliance**

(1) **Universal Precautions (Standard Precautions)**. This method of infection control requires all employees and inmates to assume that all human blood and specified human body fluids are infectious for HIV, HBV, and other bloodborne pathogens.

(2) **Engineering and Work Practice Controls**. The institution ECP will define the position or department responsible for examining, maintaining, and/or replacing engineering and work practice controls on a regular schedule to ensure their effectiveness.

(3) **Personal Protective Equipment (PPE)**. The institution ECP will identify the person or department responsible for:

- Requiring the use of personal protective equipment.
- Providing personal protective equipment.
- Ensuring that personal protective equipment is properly used, stored, cleaned, laundered, repaired, replaced, or discarded as needed.
- Investigating and documenting circumstances in which ppe was not used in order to determine whether changes can be instituted to prevent such occurrences in the future.

Inmates may **never refuse** to wear personal protective equipment.

(4) **Housekeeping**. Each institution will develop a housekeeping plan to assign responsibilities in keeping a clean and sanitary environment. The plan will include a written cleaning schedule.

The Warden will assign a person to be responsible for developing and maintaining the plan. The HSA will review the plan to ensure it complies with the requirements of 29 CFR 1910.1030.

(5) **Regulated Medical Waste**. Each institution will have local policies and procedures for the handling, collecting, transporting, and storing regulated medical waste. Regulated waste management must meet OSHA standards and comply with respective state and local requirements, and local security procedures.

The HSA and Safety Manager have joint responsibility for written procedures for the management of regulated medical waste.

Disposal of all regulated medical waste must be in accordance with applicable regulations of the United States, States and Territories, and political subdivisions of States and Territories.

Regulated waste will be stored in a manner and location that maintains the integrity of the packaging and provides protection from outside elements, rodents, and vermin. Regulated waste will be stored in the following manner:

- Out of sight of inmates and visitors in a non- congested area.
- In a locked storage area with a biological hazard symbol posted on the door.
- The storage area must have an exhaust system to the outside and a smooth, impervious floor.

(6) **Laundry**. Each institution will include in the Health Services Policy and Procedure Manual procedures for the handling and bagging, laundering (on-site), storage, and transport of linens contaminated with blood or body fluids in accordance with the 29 CFR 1910.1030, Bloodborne Pathogen Standard, state and local sanitation requirements.

c. **Bloodborne Pathogen Post-Exposure Evaluation and Follow-Up**

(1) Inmates at risk of work exposures who believe that they have been exposed to an infectious disease, blood, or body fluids while on duty will report the exposure to their supervisor and the Health Services Unit where an Inmate Injury Assessment and Follow-Up (BP-A362) will be completed.

(2) Inmates in non-work related situations who believe they have been exposed to an infectious disease will report to the Health Services Unit for clinical evaluation.

(3) The CD/staff physician will determine the occurrence of a bloodborne exposure.

(4) The CD will promptly order mandatory testing on any inmate sentenced to a term of imprisonment for a Federal offense, or ordered detained before trial, when there is well-founded reason to believe the inmate may have intentionally or unintentionally transmitted HIV to any officer or employee of the United States, or to any non-inmate who is lawfully present in a correctional facility.

(a) Consistent with this Program Statement, when there is a determination of an exposure to HIV, medical staff will inform any person who may have been exposed to HIV (in, as appropriate, confidential consultation with the person's physician), of the potential risk involved and, if warranted by the circumstances, that prophylactic or other treatment should be considered.

(b) The inmate who may have transmitted HIV will be tested promptly for the presence of HIV, and the test results will be communicated to the inmate tested.

(c) Employees will be told if an exposure incident was negative for HIV.

(d) If the results of a test indicate a source positive for the presence of HIV, the BOP will:

- Advise the tested inmate that the test was positive for the presence of HIV, and provide the inmate with appropriate counseling, health care, and support services.
- Provide the affected officer or employee of the United States access to medically necessary health care.
- Provide all other non-inmate individuals who are lawfully present in the correctional facility with information about national hotlines, health care referral centers, and other resources of information concerning treatment for HIV and AIDS. **The local procedure for providing and documenting the information provided to these individuals will be defined in the ECP**.

(5) If there has been a determination of a bloodborne exposure to an infectious disease other than HIV, the source inmate will be tested according to 28 CFR 549.12. Refer to Section 7.c., Diagnostics, of this Program Statement.

(6) Once a determination is made that a bloodborne exposure has occurred, the exposed inmate will be offered emergency care, evaluation, and prophylaxis in accordance with the U.S. Public Health Service recommendations, 18 U.S.C. § 4014, and guidance from the Medical Director.

(7) If the inmate is due for release from custody and will require continuation of recommended treatment, the inmate must sign an Authorization for Release of Medical Information form (BP-A0621) to allow release of the information to a community provider. Preparation for transitional medical needs should be initiated in advance for continuity of prescribed treatments.

(8) The CD will ensure that all post-exposure medical evaluation and follow-up is documented in the medical record. At a minimum, this documentation will include:

- The routes of exposure and a detailed account of how the exposure occurred (work related or non-work related).
- All medical and prophylactic treatments received and counseling.
- Completion of the Inmate Consent/Declination for HIV Post-Exposure Prophylaxis (PEP) form (BP-A1053), when indicated.
- Assurance that the exposed inmate has been informed of potential risks of infection, precautions to prevent potential transmission of infection, and the results of the evaluation, including any medical conditions resulting from the exposure incident, that may require further evaluation or treatment.
- Protection of the privacy of the exposed/injured person according to the Privacy Act.

- Exclusion of specific names of source individuals on the medical record for inmate exposures.

d. **Communication of Hazards: Use of Labels and Signs**. Each institution will include in the Health Services Policy and Procedure Manual procedures for the use of labels and signs that are in compliance with 29 CFR 1910.1030, federal, state, and local regulations.

12. **INFECTIOUS DISEASE TRAINING AND PREVENTIVE MEASURES**

§549.15. Infectious disease training and preventive measures.

a. The HSA will ensure that a qualified health care professional provides training, incorporating a question-and- answer session, about infectious diseases to all newly committed inmates, during Admission and Orientation.

b. Inmates in work assignments which staff determine to present the potential for occupational exposure to blood or infectious body fluids will receive annual training on prevention of work-related exposures and will be offered vaccination for Hepatitis B.

(1) **Inmate Orientation**. All inmates entering Bureau facilities will receive education on the following infectious disease topics:

- HIV infection, including general review of current information on HIV transmission, prevention, disease course, and treatment options.
- Tuberculosis, including general review of current information on tuberculosis transmission, prevention, surveillance (skin-testing), latent TB infection, disease course, and treatment.
- Viral Hepatitis and sexually transmitted diseases, including general review of current information on transmission, treatment, and prevention.

(2) **Bloodborne pathogen and TB control training** will be provided to all inmate workers consistent with the requirements stipulated in 29 CFR 1910.1030 and will contain the following elements:

- Obtaining copies of applicable regulatory texts with an explanation of their contents.
- Information on the epidemiology and symptoms of bloodborne diseases and TB.
- Ways in which bloodborne pathogens and TB are transmitted.
- Explanation of the ECP and how to obtain a copy.
- Information on recognizing tasks that might result in occupational exposure.

- Explanation of standard precautions, the use and limitations of work practice, engineering controls, and personal protective equipment.
- Information on the types, selection, proper use, location, removal, handling, decontamination, and disposal of personal protective equipment.
- Information on hepatitis B vaccination such as safety, benefits, efficacy, methods of administration, and availability.
- Information on who to contact and what to do in an emergency.
- Information on reporting an exposure incident and on the post-exposure evaluation and follow-up.
- Information on warning labels, signs (where applicable), and color-coding.
- Question and answer session on any aspect of the training.

(3) **Preventive Measures (Hepatitis B Vaccination)**. Each institution will include in the ECP which inmate work assignments have the potential for exposure to blood and body fluids and includes, but is not limited to:

- Inmates who are assigned to a blood/body fluid spill team.
- Inmate workers who handle laundry contaminated with blood or body fluids.
- Inmates assigned to Health Services.

Inmates will be offered the Hepatitis B vaccine in compliance with 29 CFR 1910.1030.

If vaccine administration is deemed appropriate and the individual consents, the health care provider will review the CDC Vaccine Information Statement on Hepatitis B vaccine with the inmate and complete the BP-A0808, Vaccine Consent – Inmates.

The hepatitis B vaccine and vaccination series will be initiated within 10 working days of initial assignment to inmates who have occupational risk for exposure to blood or other potentially infectious materials and according to the institution's ECP unless:

- The individual declines the vaccination; **or**
- The individual has previously received the complete hepatitis b vaccination series; **or**
- Medical contraindications exist.

Inmates who decline the vaccination will sign the BP-A0808, indicating that they are declining the vaccine. An inmate may request and obtain the vaccination at a later date if he/she continues to be in an exposure-prone job.

(4) **Training Records**. Each institution's ECP will identify the person or department responsible for maintaining the training records as required by 29 CFR 1910.1030.

13. **SHARPS SAFETY PROGRAM**.

Each institution will establish a Sharps Safety Program as a component of the institution ECP. The ECP will define the person or department responsible for the program. The program will consist of the following:

a. **Sharps Injury Log**

(1) The Safety Manager is responsible for establishing and maintaining a Sharps Injury Log for the recording of percutaneous injuries from contaminated sharps. All sharps injuries must be reported to the Safety Manager.

(2) The Infection Control Officer in conjunction with the Safety Manager will ensure that sharp injuries are tracked on an ongoing basis to include information that will identify high risk areas and assist in the selection and review of safety devices.

b. Evaluation of injuries and medical devices will be documented and reported to Infection Control, Safety, and Quality Improvement Program committees.

c. The annual review and update of the ECP will reflect the process for documentation of the evaluation and implementation of appropriate commercially available and effective safer medical devices.

The annual review and update of the ECP will reflect the process for solicitation of input from non-managerial employees responsible for direct patient care. This will include employees who have the potential for exposure injuries from contaminated sharps in the identification, evaluation, and selection of effective engineering and work practice controls and documentation of this solicitation in the ECP.

d. The Sharps Safety Program will account for the actions necessary to reduce exposure to bloodborne pathogens by incorporating technologic innovations.

14. **EXPOSURE TO AIRBORNE DISEASES**

Respiratory protection devices help prevent exposure by inhalation of infectious airborne nuclei. Such equipment must be NIOSH certified and provide a filter efficiency of 95% or better (i.e., N95 or a high efficiency particulate air filter).

Each institution will purchase NIOSH certified particulate respirators (N95 or HEPA) of appropriate sizes necessary for all staff designated for fit-testing and store them in the Health Services storage area. Particulate respirators should be available in work areas where clinical assessment and identification of a TB suspect may occur.

a. The cost of purchasing NIOSH respirators and training and fit-testing will be incurred locally.

The Safety Manager is to provide the Business Office a list of recommended vendors for purchase.

b. The Safety Manager or designee at each institution is to be trained in the necessary functions to provide fit testing of TB respirators for inmates that require training. Subsequently, the Safety Manager or designee, will provide each inmate at risk of work-related exposure who is fitted with a NIOSH respirator, the training necessary in its wear and use.

All training for the inmate worker at risk on TB respirator use is to be documented and placed on inmate's training record. The HSA will ensure inmate training records are placed in the Inmate's Central File.

c. **Tuberculosis Exposures**. Following an incident in which an inmate(s) may have been exposed to tuberculosis, the inmate(s) will be tested according to 28 CFR 549.12(b). 20 CFR 549.12(b) refers to Section 7.b.(3),(4), and (5) of this Program Statement.

Once an institution physician determines a TB exposure has occurred, the exposed individuals will be offered evaluation and treatment for latent TB in accordance with the U.S. Public Health Service recommendations and guidance from the Medical Director.

Federal Bureau of Prisons
Health Services Division

Pandemic Influenza Plan

Module 1:
Surveillance and Infection Control

October 2012

BOP Pandemic Influenza Response Stages

The BOP *Pandemic Influenza Plan* is divided into the three stages that are used for standard BOP contingency plans; in this plan, the three stages are designed to correlate with the Federal Government Response Stages for pandemic influenza.

The BOP Pandemic Influenza Response Stages are as follows:

- **PREPARATION** (Federal Response Stages 0–1). Most of the detail in this plan involves the preparation phase.
- **RESPONSE** (Federal Response Stages 2–5). This phase, which begins when it is announced that there are confirmed human outbreaks overseas, involves both making last-minute preparations and actually responding to pandemic flu.
- **RECOVERY** (Federal Response Stage 6). This phase involves recovering from the pandemic, evaluating actions taken during the pandemic, and preparing for more flu. Based on what we know from previous pandemics, subsequent waves of flu are likely to follow once the pandemic flu has subsided.

Federal Government Response Stages*		BOP Influenza Plan	
		Federal Stages	BOP Stage
0	New domestic animal outbreak in at-risk country	**0-1**	**PREPARATION**
1	Suspected human outbreak overseas		
2	Confirmed human outbreak overseas	**2-5**	**RESPONSE**
3	Widespread human outbreaks in multiple locations overseas		
4	First human case in North America		
5	Spread throughout United States		
6	Recovery & preparation for subsequent waves	**6**	**RECOVERY**

** The Federal Government Response Stages should not be confused with the World Health Organization phases of pandemic influenza.*

Table of Contents

Overview

Starting now, every BOP institution should creatively and aggressively promote three health habits that interrupt flu transmission: regular hand hygiene, respiratory etiquette (coughing or sneezing into a sleeve or tissue); and avoiding touching one's mouth, nose or eyes).

This guidance provides general information about pandemic influenza. In the event of a pandemic, specific guidance related to that event will be issued by the Medical Director.

During the 1918–19 pandemic influenza ("flu"), certain cities fared better than others. Those U.S. cities that both acted promptly to control the flu *and* implemented multiple layers of protective measures had fewer flu cases and lower overall mortality. The procedures for surveillance and infection control outlined in this plan include multiple layers of protection. With the onset of pandemic flu, the BOP Medical Director will guide implementation of infection control measures based on the severity of the flu outbreak. The key to protection of both employees and inmates is swift, decisive, coordinated action based upon advance planning.

How is flu transmitted?

When people who are sick with the flu either cough or sneeze, they release infectious droplets that can enter another person's body through their eyes, nose, or mouth. Flu germs can spread through the air, up to six feet away from the sick person. Flu virus particles do not remain suspended in the air. However, if a person who is sick with the flu touches surfaces, such as telephones and door knobs, the surface can become contaminated with the flu virus. Other people then can become infected with the virus by touching the surface and then touching their eyes, nose, or mouth.

When can a person transmit flu?

For the purposes of this guidance, the *infectious period* for influenza is generally defined as: one day before fever starts until 24 hours after fever ends. Some people may shed virus for a while longer; however, studies have shown that after fever resolves there is a significant reduction in the ability to transmit infection.

How long does it take for symptoms develop?

The estimated *incubation period* (the time between acquiring influenza and becoming ill) is generally 1–4 days (average: 2 days).

Surveillance

Surveillance refers to the process of detecting and tracking diseases. Surveillance for flu involves screening for influenza symptoms (to rapidly identify flu patients and isolate them); and collecting, analyzing, and reporting data on individuals who are diagnosed with influenza-like illness. The BOP utilizes the following definition of influenza-like illness:

> ***Influenza-like illness (ILI):*** *Fever (temperature of 100° F [37.8° C]) plus either cough or sore throat—in the absence of a known cause other than influenza.*

During a pandemic of influenza, ILI will be tracked utilizing BEMR. On a daily basis, enter into BEMR the occurrence of: ILI, complicated ILI (requiring prescription medication or intravenous fluids), ILI related hospitalization, and ILI related deaths. This will allow local facilities and the central and regional offices to closely track the occurrence of ILI within BOP. See *Attachment 1.2* for specific BEMR codes and definitions.

Infection Control

Infection control consists of practices that interrupt the spread of disease. A variety of measures to interrupt flu transmission are listed in *Table 1* below and discussed on the following pages.

Table 1. Pandemic Flu Infection Control Measures

1. Promote good health habits among employees and inmates:
   a. Regular hand hygiene
   b. Respiratory etiquette (coughing or sneezing into a sleeve or tissue)
   c. Avoiding touching one's eyes, nose, or mouth
2. Conduct frequent environmental cleaning of "high touch" surfaces.
3. Separate the sick from the well.
   a. Advise employees to stay home from work if they are sick.
   b. Promptly identify and contain inmates with influenza-like illness (ILI).
   c. Isolate or cohort inmates who are sick with pandemic influenza.
   d. Conduct contact investigations for flu cases and quarantine contacts.
4. Create "social distance" between people.
5. Use personal protective equipment (PPE) for close contact with flu cases.
6. If widespread flu transmission, consider targeted distribution of face masks (only with permission of BOP Medical Director or designee).
7. Provide ongoing infection control education.

1. Promote good health habits among employees and inmates.

Critical to preventing flu transmission is a triad of good health habits, including:

a. Regular hand hygiene
b. Respiratory etiquette (coughing or sneezing into a sleeve or tissue)
c. Avoiding touching one's eyes, nose, or mouth

Preparing for pandemic flu involves improving compliance with these basic infection control measures, *beginning now*. Each facility should assure that adequate supplies and facilities are available for hand washing for both inmates and employees.

Health care workers should have access to alcohol-based hand rub provided in accordance with fire and safety rules. CDC has made no recommendations regarding the use of non-alcohol based hand rub, but use of these products is presumably better than no hand hygiene at all. Provision of non-alcohol based hand rub via dispensers should be considered in key areas that lack facilities for hand washing, i.e., outside the dining hall, in the visitor area, etc.

Provisions should be made for employees and visitors to wash their hands before and after they enter the facility. The triad of good health habits should be promoted in various ways, i.e., educational programs, posters, campaigns, assessing adherence with hand hygiene, etc. Relevant educational tools are available on Sallyport on the Health Services Division page.

2. Conduct frequent environmental cleaning of "high-touch" surfaces.

Another general infection control measure is to routinely clean surfaces that are frequently touched and therefore can become contaminated with germs. These can include door knobs, keys, hand rails, telephones, computer keyboards, elevator buttons, inmate cell bars, etc. Increasing the frequency of environmental cleaning of these surfaces is something that also can be started now, thereby preventing transmission of infections such as the common cold, seasonal flu and MRSA. Some facilities have increased environmental cleaning of high-touch surfaces by increasing the number of inmate workers assigned to this duty.

3. Separate the sick from the well.

Transmission of pandemic flu can be prevented by separating those who are ill from those who have not been infected. In the event of pandemic flu, several measures should be implemented to separate the sick from the well. Below in *Table 2* are definitions of two important terms related to separating the sick from the well and that are frequently confused with each other.

Table 2. Definitions of "Isolation" and "Quarantine"

Isolation: Confining individuals who are **sick with influenza** (ILI cases) either to single rooms or by cohorting them with other influenza patients.
Quarantine: Confining asymptomatic persons who are **contacts of influenza cases**, while they are in the incubation period (until 4 days after exposure ended).

The following measures are recommended to separate the sick from the well.

a. Advise employees to stay home from work if they are sick.

The most likely way that pandemic flu will gain entrance to a facility is via infected employees. In the event of pandemic flu, staff should be educated to stay home if they have influenza symptoms. If employees become sick at work, they should be advised to promptly report this to their supervisor and go home. In general, the timetable for returning to work is 24 hours after a person's temperature returns to normal.

b. Promptly identify and contain inmates with influenza-like illness (ILI).

Prompt identification and isolation of inmates with ILI is critical. During the course of pandemic influenza, *all* inmates should be screened at intake, based upon guidance from the Medical Director. If ILI is circulating within the institution, inmates should be screened at triage/sick-call and prior to transfer or daily transport. In addition, all staff should be advised to report if any inmates are symptomatic.

Immediately place a face mask on all individuals who are identified as having ILI symptoms (if it can be tolerated). They should be isolated or cohorted with other sick inmates (see below).

Screening at intake: The screening of inmates upon arrival should be adapted to the particular situation at each facility, with the goal of keeping new arrivals segregated from other inmates, until the screening process has been completed. Screening should be conducted utilizing the revised *Influenza-Like Illness Screening Form (Attachment 1.3)*.

Screening at triage/sick-call: If ILI is circulating within the institution, inmates at sick-call should be asked about ILI symptoms; if symptoms are present, these inmates should be asked to wear a face mask and be physically separated from inmates presenting to sick-call for other reasons.

Screening of transfers and daily transports: If ILI is circulating within the facility, inmates should be screened for ILI prior to transport. If ILI is identified in an inmate, in general, their transfer or transport should be postponed until the inmate has been fever-free for 24 hours (without fever-reducing medication).

c. Isolate or cohort inmates who are sick with pandemic influenza.

A critical infection control measure for pandemic influenza is to promptly separate inmates who are sick with flu symptoms away from other inmates in the general population. Inmates can be *isolated* in private rooms. Alternatively, groups of sick inmates can be *cohorted* together in a separate unit.

Rooms where inmates with ILI are either housed alone or cohorted should be designated "Influenza Isolation Units" (see *Attachment 1.7*). In general, no special air handling is

needed. Depending on how ill the inmates are, bunk beds may or may not be suitable. Ideally, the unit should have a bathroom attached. If not, inmates will have to wear a face mask to go to the bathroom outside the room. The door to the Influenza Isolation Unit should remain closed. A sign should be placed on the door of the room indicating that it is an Influenza Isolation Unit and listing recommended personal protective equipment (PPE) (see *Attachment 1.10*).

Within Influenza Isolation Units, Standard Precautions should be followed. The type or respiratory protection required (i.e., face mask vs. respirator) will be based on guidance from the Medical Director during the pandemic. Healthcare personnel caring for patients should wear gloves for all interactions that may involve contact with the patient or potentially contaminated areas in the patient's environment.

If the inmate with ILI must be taken out of isolation, a face mask should be placed on the sick inmate to reduce the risk of spray through cough or sneeze.

If the inmate with ILI must undergo a procedure that is likely to generate aerosols (e.g., suctioning, administering nebulized medications), then an airborne infection isolation (AII) room with negative pressure and 6 to 12 air changes per hour, is indicated. A respirator, eye protection (goggles or face shield), and a gown should be worn during patient care activities that are likely to generate splashes and sprays of blood, body fluids, secretions, or excretions, e.g., suctioning or nebulizer treatments.

In large dorm settings or camps, isolation may not be a possibility. If isolation is not feasible, attempt to place the beds of sick inmates at a distance of at least 6 feet from other inmates. It is recognized that if there is widespread flu transmission within a facility, isolation as a strategy may not be feasible.

See *Attachment 1.7* for more information about infection control procedures for Influenza Isolation Units. Personal protective equipment in isolation units is discussed on the next page.

d. Conduct contact investigations for flu cases and quarantine contacts.

It may be appropriate to identify close contacts to pandemic flu cases and quarantine them in a separate unit. The purpose of quarantine is to assure that inmates who are known to have been exposed to the flu virus are kept separate from other inmates to assess whether they develop flu symptoms. For the purposes of this document, exposure is defined as having been in a setting where there was a high likelihood of contact with respiratory droplets and/or body fluids of a person with ILI. Examples of close contact include sharing eating or drinking utensils, or any other contact between persons likely to result in exposure to respiratory droplets. Close contact typically does not include activities such as walking by an infected person or sitting across from a symptomatic patient in a waiting room or office.

Within the BOP, the duration of quarantine during pandemic influenza is 4 days. As feasible, the beds/cots of quarantined inmates should be placed at least 3-6 feet apart. Quarantined inmates should be restricted from being transferred, having visits, or mixing with the general

population. See *Attachments* 1.8 and 1.9 for procedures and forms related to contact investigation and quarantine. A face mask is recommended for staff who are in direct, close contact (within 6 feet) of quarantined inmates.

Note: *Once multiple flu cases occur within multiple housing units, a decision may be made to abandon contact investigation and the subsequent quarantine of contacts. In this case, everyone in the facility has become a "contact," and contact investigation and quarantine are no longer useful or appropriate control strategies.*

4. Create "social distance" between people.

In the general community, an important method for preventing pandemic flu transmission will be to increase the distance between people by instituting various "social distancing" measures, e.g., closing schools, theaters, and churches; staggering work schedules; discouraging use of public transportation, etc. While "social distancing" is more difficult to accomplish in a correctional setting, there are possible interventions.

Social distancing measures in BOP facilities could include: limiting gatherings (group meals, religious services, work, classes, recreation, common areas); ending visitation; halting entrance to volunteers and contractors; discouraging shaking of hands, etc. Individual units can be taken separately to recreation and the dining hall with thorough environmental cleaning in between. Each local pandemic flu planning committee should identify ways to accomplish social distancing within their facility.

With the occurrence of multiple cases of flu, lock-down—of individual dormitories, buildings, and entire institutions—should be considered on a case-by-case basis, in consultation with the Regional Medical Director.

5. Use personal protective equipment for close contact with flu cases.

Anyone who is working in close contact with pandemic flu cases should be provided personal protective equipment.

a. Respiratory Protection: Face masks (not respirators) are recommended for use with *seasonal* flu patients because the primary mode of flu transmission is droplet spread (not airborne). Respirators are generally utilized to protect against small airborne particles, e.g., with tuberculosis patients.

Table 3. Updated Definitions of "Face Masks" and "Respirators" (CDC-2009)
Face Masks: Disposable FDA-approved masks, which come in various shapes and types (e.g., flat with nose bridge and ties, duck billed, flat and pleated, pre-molded with elastic bands). They include the following categories of masks: surgical, dental, medical procedure, and laser.
Respirators: N-95 or higher filtering, face-piece respirators that are certified by CDC/NIOSH.

In the event of a pandemic flu, the use of respirators may be indicated, based on guidance from the CDC and the BOP Medical Director. Respirators should be worn in situations in which the virus may be aerosolized, including aerosol-generating procedures (such as endotracheal intubation, nebulizer treatments), resuscitation of a patient, or when providing direct care to a patient with confirmed or suspected influenza-related pneumonia.

b. Gloves: Healthcare personnel caring for patients should wear gloves for all interactions that may involve contact with the patient or potentially contaminated areas in the patient's environment. If gloves are worn, perform hand hygiene before donning and after removing gloves.

c. Eye protection and gowns should be worn by health care personnel when spray or splash or body fluids, secretions, or excretions is anticipated, e.g., suctioning, administering nebulized medication. Eye glasses are *not* sufficient for eye protection. Appropriately fitted, indirectly-vented goggles with a manufacturer's anti-fog coating provide the most reliable, practical eye protection from respiratory droplets, and they come in styles that can be fitted over eye glasses. Face shields can be used as an infection control alternative to goggles.

d. Face masks are the recommended personal protective equipment when in close contact (within 6 feet) of quarantined inmates (housing of asymptomatic contacts who have been exposed to ILI). Face masks do not require fit-testing. Face masks also should be placed on persons with ILI to prevent droplet spread, i.e., during transport.

6. If widespread flu transmission, consider targeted distribution of face masks.

It is unknown whether the targeted distribution and use of face masks during a pandemic flu outbreak will interrupt the spread of flu. Because of the close contact between people in BOP facilities, face masks have been stockpiled for distribution to employees and inmates in the event of pandemic influenza. Permission must be obtained from the BOP medical director prior to targeted distribution of face masks.

7. Provide ongoing infection control education.

Successful response to pandemic flu will depend greatly on strong education efforts prior to and during an actual event. The education for pandemic flu infection control is closely related to other important infection control education for BOP facilities. Education about hand hygiene, respiratory etiquette, and environmental cleaning provides benefits to inmates and employees with regard to a variety of infectious diseases. Infection control education should be ongoing—the more the better. Using a variety of media (posters, newsletters, video) increases the likelihood that employees and inmates will comply with infection control recommendations. The Central Office Health Services Division provides educational tools on Sallyport and will offer periodic Centra programs related to pandemic flu.

Influenza Outbreak Scenarios and Control Measures

Three influenza outbreak scenarios and associated infection control measures have been developed, based on the number of ILI cases occurring and their distribution within a facility (see *Attachment 1.1*).

The three scenarios include:

- ***Isolation Scenario*** – single cases of ILI with minimal to no transmission
- ***Quarantine Scenario*** – ILI confined to single housing unit(s) or building
- ***Widespread Transmission Scenario*** – ILI occurring throughout the institution

For each scenario, general recommendations are made about the appropriate infection control measures to implement. The control measures listed for each scenario are provided for general reference only. Consult the Regional Office for guidance on management of specific outbreak situations.

Action Steps by Pandemic Stage

Preparation (Federal Response Stages 0–1)
(See *Standard Operating Procedures*, which are provided for the Preparation stage only.)

1. Identify a staff person to be responsible for influenza surveillance and infection control.
2. Increase emphasis on good health habits to stop flu transmission, especially hand washing, respiratory etiquette, and avoiding touching the eyes, nose, and mouth.
   - **a.** Make soap dispensers or hand soap available in all employee and inmate restrooms.
   - **b.** Institute a plan to assure that soap dispensers are refilled regularly .
   - **c.** Assure that inmates have an adequate supply of bar soap.
   - **d.** Provide education to employees and inmates on hand hygiene, respiratory etiquette, and avoiding touching the eyes, nose, and mouth.
   - **e.** Maximize access to alcohol-based hand rub dispensers in the Medical Unit (only if authorized by the warden).
   - **f.** Regularly assess the hand hygiene practices of employees and inmates, and design measures to improve hand hygiene.
   - **g.** Assure that employees and visitors can wash their hands when entering and leaving the facility.
3. Emphasize frequent cleaning and disinfection of high-touch areas, i.e., door knobs, keys, telephones.
4. Identify resources for influenza surveillance and control.
   - **a.** Track international, national, regional, and local influenza trends.
   - **b.** Identify public health department contacts for influenza (including 24/7 contact information).
   - **c.** Communicate with your local health department and discuss collaboration on pandemic influenza preparedness.
   - **d.** Identify any local or state reporting requirements for influenza/pandemic influenza.
   - **e.** Identify laboratories capable of processing influenza cultures and cultures for novel (pandemic) influenza.
5. Begin tracking influenza trends by conducting surveillance for *seasonal* flu.
6. Establish procedures for influenza screening to be utilized with pandemic flu.
7. Identify administrative measures to accomplish "social distancing."
8. Identify areas within the facility that can be used for isolation and quarantine.
9. Develop plans for stockpiling and distributing infection-control supplies.
10. Provide routine training about flu transmission and prevention and control measures.
11. Conduct mock exercises related to surveillance and infection control in pandemic flu.

(continued on next page)

Response (Federal Response Stages 2-5)

Begin when there are confirmed human outbreaks of pandemic flu anywhere in the world:

1. Reinforce education regarding influenza infection control. Emphasize the triad of good health habits: hand hygiene, respiratory etiquette, and not touching the eyes, nose, and mouth.
2. Consider placement of dispensers of non-alcohol hand rub in key areas that lack facilities for hand washing, i.e., outside the dining hall, in the visitor area, etc.
3. Increase environmental cleaning of "high-touch" surfaces, e.g., door knobs, keys, telephones.
4. Educate employees and visitors not to come to the facility if they have flu symptoms.
5. Assess adequacy of infection-control supplies (including face masks, respirators, and gloves) and review distribution plan.
6. If indicated by the Medical Director, provide respirator fit-testing, medical evaluation, and training to any employees who may be assigned to have contact with inmates with flu—in Influenza Isolation Units or for transport.
7. Initiate screening for influenza-like illness at intake and in triage/sick-call according to those outlined in the Standard Operating Procedures (see *Attachment 1.3*).
8. Conduct active surveillance to look for influenza cases (i.e., review temperature logs, triage/sick call, hospitalizations, staff absences, unexplained deaths, etc.).
9. On a daily basis, enter into BEMR: cases of ILI, complicated ILI, ILI-related hospitalizations, and ILI-related deaths. Produce regular reports on the status of ILI within the institution for institution leadership.
10. Review possible measures to increase "social distancing."
11. Review/revise the list of designated influenza isolation and quarantine units, and develop options for expanding bed-space as needed.
12. Advise health care workers to report any unprotected close contact with persons with ILI (either at work or at home).

Begin after a suspected pandemic influenza case is diagnosed in the facility:

13. Immediately isolate (or cohort) inmates with influenza-like illness in "Influenza Isolation Units", using the influenza precautions outlined in *Attachment 1.7*.
    - **a.** Reinforce education of staff on infection control procedures to follow when caring for flu patients.
    - **b.** Assure that adequate infection-control supplies and personal protective equipment, i.e., face masks, respirators, and gloves, are available.
    - **c.** Place precaution signs (*Appendix 1.10*) on the doors of Influenza Isolation Units.
14. If there is flu transmission in the facility, begin screening all transfers and daily transports for ILI (see *Attachment 1.3*).

15. Perform triage at sick-call to rapidly identify inmates with flu symptoms and implement procedures for separating the sick from the well.

16. Conduct contact investigations of the initial flu cases that have been identified, and quarantine contacts according to procedures outlined in *Attachment 1.8*. Place quarantine precaution sign (*Attachment 1.10*) on the doors and assure an adequate supply of face masks. Implement daily temperature and signs and symptoms check. Immediately isolate any inmates that develop ILI symptoms.

Note: *If there are multiple pandemic flu cases in multiple housing units, implementing contact investigations and quarantine may be inappropriate and abandoned as a strategy.*

17. Implement measures to increase social distancing.

18. Review Influenza Outbreak Scenarios and Control Measures (*Attachment 1.1*) to assess the current status of an outbreak in the institution and identify appropriate control measures.

19. Continue staff and inmate training on infection control.

20. Monitor adherence to infection control guidelines.

21. Monitor daily use of infection control supplies and conduct daily inventory control.

Recovery (Federal Response Stage 6)

Previous flu pandemics have been associated with subsequent "waves" of flu after an initial wave resolves. After an initial pandemic flu outbreak, subsequent outbreaks are likely. The recovery period will involve both recovering from the pandemic emergency, evaluating the BOP response to it, and preparing for subsequent waves of pandemic flu.

1. Maintain surveillance for influenza (to detect subsequent waves of pandemic influenza).

2. Evaluate the effectiveness of surveillance and infection-control measures during the pandemic flu and summarize observations.

3. Evaluate the adequacy of infection control supplies and the need for restocking.

4. Restock infection control supplies.

Module 1: Surveillance and Infection Control
Standard Operating Procedures for Preparation Stage
(Federal Response Stages 0–1)

During the Preparation stage, adapt this Standard Operating Procedure template to the unique circumstances of your facility. A modifiable Word version is posted on: www.bop.gov/news/medresources.jsp.
1. Identify staff persons responsible for planning for and directing health care delivery during pandemic influenza.
In this facility, the following individual is assigned responsibility:
2. Increase emphasis on the triad of good health habits to stop flu transmission: hand washing, respiratory etiquette, and not touching the eyes, nose and mouth.
a. Make soap dispensers or hand soap available in all employee and inmate restrooms, as follows:
b. Institute a plan to assure that soap dispensers are refilled regularly, as follows:
c. Assure that inmates have an adequate supply of bar soap, as follows:
d. Provide education to employees and inmates on hand hygiene, respiratory etiquette, and avoiding touching the eyes, nose, and mouth.
Employees will be provided regular education as follows:
Inmates will be provided regular education as follows:
Posters on hand hygiene and respiratory etiquette will be placed in the following locations:
e. Maximize access to alcohol-based hand rub dispensers in the Medical Unit (only if authorized by the warden) as follows:
f. Regularly assess the hand hygiene practices of employees and inmates, and design measures to improve hand hygiene. Implement systems for assessing adherence to hand hygiene as follows:
For health care workers:
For other correctional workers:
For inmates:

g. Assure that employees and visitors can wash their hands when entering and leaving the facility, as follows:

3. Emphasize frequent cleaning and disinfection of high touch areas.

a. Identify "high-touch" surfaces in this facility (i.e., door knobs, keys, telephones):

b. The following plan will be implemented to increase frequency and the extent of cleaning and disinfection of high-touch surfaces in this facility:

4. Identify resources for influenza surveillance.

a. Track international, national, regional, and local influenza trends, utilizing the following resources. Increase frequency of monitoring when pandemic flu is reported outside North America.

Federal Bureau of Prisons Intranet: *http://sallyport.bop.gov*
Federal Web sites on pandemic influenza: *http://www.flu.gov/*
Centers for Disease Control and Prevention: *www.cdc.gov/flu/weekly/fluactivity.htm*

b. Identify public health department contacts for influenza (include 24/7 contact info.)

Local County/Community Public Health Contact:

Address:

Phone/email:

State Health Department Contact:

Address:

Phone/email:

c. Communicate with your local health department and discuss collaboration on pandemic influenza preparedness. Document the plans discussed.

d. Identify any local or state reporting requirements for influenza/pandemic influenza.

☐ No reporting requirements

☐ Influenza reporting requirements for _____ <jurisdiction> are:
(Also attach required reporting forms.)

e. Identify laboratories capable of processing influenza specimens and specimens for novel (pandemic) influenza.

☐ Attach copy of procedures for obtaining influenza specimens for your lab.

	Reference Lab	State Lab
Laboratory Name		
Contact Person		
Address		
Telephone		
FAX		
email		

5. Begin tracking influenza trends by conducting surveillance for *seasonal* flu.

a. Initiate routine data collection on inmates with identified influenza-like illness (ILI). Enter data on occurrence of ILI in the BOP Electronic Medical Record.

Note: *Influenza-like illness (ILI) is defined as "fever (temperature of 100° F [37.8° C]) plus either cough or sore throat—in the absence of a known cause other than influenza."*

In this facility, surveillance for influenza-like illness (ILI) will be accomplished as follows:

b. Obtain influenza specimens when there is atypical clinical presentation of flu or when an individual is hospitalized for severe respiratory illness during flu season.

Note: *There is no need to collect specimens during an ongoing influenza outbreak.*

c. Compile annual summary reports on seasonal influenza cases (Oct. 1 – Apr. 30). Review annual ILI statistics with the Infection Control Committee. .

6. Establish procedures for influenza screening to be utilized with pandemic flu.

a. New Inmate Arrivals: Employees shall be assigned to screen all new arrivals, using the *Influenza-Like Illness Screening Form (Attachment 1.3)*. This screening will include taking the inmate's temperature and asking questions about symptoms. If the inmate's condition meets the clinical definition of influenza-like illness, then further questions shall be asked to identify risk factors for pandemic influenza. Ideally, screening will take place individually as the inmates are departing the bus, prior to entering the holding area. Depending on weather conditions and physical layout, this may not be feasible. Plans for screening should be adapted to the particular situation at each facility, with the goal of keeping the new arrivals segregated from other inmates, until the screening process has been completed.

The plan for screening new inmate arrivals in this facility is:

If ILI is identified in an arriving inmate the following should occur:

- Place a face mask on the inmate.
- Walk the inmate to the designated influenza isolation area.
- Quarantine all inmates arriving on the same bus in one area of the facility, for 4 days.

b. Triage/Sick-Call: During the Response stage, inmates who come to sick-call/triage will be screened for flu symptoms as follows:

Any inmate who has flu-like symptoms will be asked to wear a mask and will be separated from other waiting inmates. If there is any evidence of epidemiologic risk for flu, the inmate should be isolated. (For more detail on infection control, isolation, and quarantine, see *Attachment 1.7*.)

c. General Inmate Screening: After cases of pandemic flu are reported, more intensive screening of the general population may be warranted. This may include obtaining screening temperatures and conducting symptom screens, as well as advising correctional officers to report any symptomatic inmates. Strategies for general screening for flu symptoms will include:

d. Employee Screening: Employees will be asked to stay home from work if they become sick with flu symptoms and to voluntarily report flu symptoms if they occur on the job.

The following system will be utilized to track and report employee illness during a pandemic flu outbreak:

7. Identify administrative measures to accomplish "social distancing."

Discuss use of various administrative measures to accomplish social distancing to prevent pandemic flu transmission in this facility.

a. Identify general "social distancing" measures. The following are possible measures:

- limit gatherings (group meals, religious services, work, classes, recreation, common areas)
- no handshaking
- stop visitation, volunteers, contractors
- limit contact between the well and the ill
- lock-downs
- providing recreation and dining separately by unit (with disinfection in-between)

The following additional social distancing measures could be utilized in this facility:

b. Separate the sick from the well in triage/sick-call. During pandemic flu, the following methods will be used to separate inmates with the flu from inmates with other health problems:

8. Identify areas within the facility that can be used for isolation and quarantine.

Identify places within your facility where inmates who have pandemic flu, or who have been in contact with flu patients, can be appropriately housed, e.g., wards, gymnasium, cafeteria.

Definitions:

- ***Isolation:*** Confining influenza cases (either to a single room or by cohorting them with other influenza patients) to decrease the likelihood of influenza transmission.
- ***Quarantine:*** Confining persons who are contacts of influenza cases, while they are in the incubation period (usually 4 days after exposure ended).

Depending on how ill the inmates are, bunk beds may not be suitable. Isolation and quarantine units do not require special air handling. Ideally, these units have an attached bathroom. (If not, inmates must wear a mask while outside the isolation or quarantine unit.) If feasible, beds/cots in quarantine units should be placed at 3–6 feet apart to decrease the likelihood of flu transmission. List possible locations for isolation and quarantine in the chart below.

Type of Room	Location(s)	Capacity (# of inmates)
Isolation (Single)		
Isolation (Cohort)		
Quarantine (Contacts)		

☐ Review procedures for pandemic influenza precautions in *Attachment* 1.7 and 1.8 and be prepared to implement them.

☐ Review procedures and forms for contact investigation and quarantine in *Attachment* 1.8 and 1.9 and be prepared to implement them.

9. Develop plans for stockpiling and distributing infection control supplies.

a. Assure that stockpiling of hand hygiene supplies and masks is consistent with guidance from the Central Office. Develop plans for storage of supplies. ***For security reasons, do not record the storage location in this document.***

b. Indicate the quota for supplies based on Central Office guidance:

- Liquid or foam hand soap Quota: ___
- Alcohol-based hand rub Quota: ___
- Face masks Quota: ___
- Bar soap Quota: ___
- N-95 respirators Quota: ___
- Gloves Quota: ___

c. The general plan for overseeing and managing stockpiled supplies is outlined below.

- The plan for rotating stock of supplies is:
- The plan for securing supplies is:
- The plan for distributing hand hygiene supplies during pandemic flu is:
- The plan for distributing and replacing face masks for inmates and employees during pandemic flu is:

d. Develop plans for conducting respirator fit-testing for staff who will be assigned responsibility for caring for pandemic flu patients.

10. Provide routine training about flu transmission, and prevention and control measures.

The plan for providing ongoing training about flu transmission, and prevention and control in this facility is:

11. Conduct mock exercises related to surveillance and infection control in pandemic flu.

Mock exercises will be conducted as follows:

Attachment 1.1. BOP Pandemic Influenza Outbreak Scenarios and Control Measures

The following chart outlines recommendations for infection control measures based on the outbreak scenario, i.e., the number and distribution of cases of ILI in an institution. These recommendations are provided for general reference only. Each outbreak situation is unique. Consult with the Regional Office regarding management of specific outbreaks.

Control Measure	Outbreak Scenario		
	Isolation *Single case(s) of ILI with minimal to no transmission*	**Quarantine** *ILI confined to single housing unit(s) or building*	**Widespread Transmission** *Multiple cases of ILI throughout institution*
Containment Goal	Prevent spread *into institution.*	Prevent spread throughout *institution/complex.*	Prevent spread *throughout* BOP.
Isolation of ILI cases	Isolate inmates with ILI in Influenza Isolation Units.	Isolate/cohort inmates with ILI, as feasible.	Cohort inmates with ILI (may not be possible).
Quarantine of flu contacts	Not applicable.	Quarantine asymptomatic contacts of flu cases, as feasible.	Quarantine not indicated. Entire institution is, in effect, "quarantined."
Respiratory Protection*	Face masks or respirators in Influenza Isolation Units.*	• Face masks or respirators in Influenza Isolation Units.* • Face mask for direct, close contact (within 6 feet) with quarantined inmates.	• Use face masks or respirators when in close contact with symptomatic inmates.* • Consider strategic distribution of face masks.**
Screening	Screen intakes.	• Screen intakes. • Screen inmates before transfer. • Screen contacts daily. • ILI case-finding throughout facility.	ILI case-finding throughout facility.
Visitors: *Visitors with ILI symptoms restricted*	No visitor restrictions except for flu case(s).	Visitor restrictions for quarantined units/buildings.	No visitors.
Antiviral Treatment	For high-risk.	For high-risk.	For high-risk.
Care for Sick	• Push fluids. • Observe closely.	• Push fluids. • Observe closely.	• Push fluids. • Observe closely.
Antiviral Prophylaxis	• Pregnant close contacts. • Consider for high-risk close contacts.	• Pregnant close contacts. • Consider for high-risk close contacts.	• Pregnant close contacts. • Consider for high-risk close contacts. • Consider for staff if severe staff shortages.**
Transfers	No transfers of flu cases.	No transfers into or out of quarantined units.	No transfers into or out of institution.

** The decision regarding the need for respirators vs. face masks will be based on guidance from the Medical Director.*
*** Only with the permission of the BOP Medical Director or designee.*

Attachment 1.2. Use of BEMR to Track Influenza-Like Illness (ILI)

The BOP Electronic Medical Record (BEMR) will permit real-time tracking of the occurrence of influenza-like illness (ILI) during the course of pandemic influenza. On a daily basis, information about the occurrence of ILI and associated events should be entered into BEMR.

Pandemic H1N1 Influenza BEMR Codes and Definitions	
488.1 A	**Influenza-Like Illness (ILI)** *Definition:* Fever (temperature of 100°F [37.8°C] or greater)—plus cough or sore throat—in the absence of a known cause for these symptoms other than influenza.
488.1 B	**Influenza-Like Illness – Complicated** *Definition:* Inmates coded as meeting the definition of ILI (BEMR 488.1 A) who require treatment with prescription medication or intravenous fluids.
488.1 C	**Influenza-Like Illness Related Hospitalization** *Definition:* Inmates coded as meeting the definition of ILI (488.1A) who are hospitalized during the course of ILI.
488.1 D	**Influenza-Like Illness Related Death** *Definition:* Inmates coded as meeting the definition of ILI (488.1A) who expire during the course of ILI or subsequent complications.

Do not change codes once they have been entered. For example, for a person who has been hospitalized, do not delete the code for hospitalization when the person returns to the facility.

Attachment 1.3. Influenza-Like-Illness (ILI) Screening Form

This form is designed to screen inmates for influenza-like illness. If pandemic influenza is circulating outside the facility, then all intakes should be screened. If pandemic influenza has been identified within the facility then screening should occur at triage/sick-call and prior to all transfers/transports.

Date: ___/___/____ **Time:** ___:___

SUBJECTIVE/OBJECTIVE

1. **Temperature** _____ Date of onset: ___/___/___
2. **Do you have any of the following symptoms:**
   - ☐ Cough
   - ☐ Sore Throat
   - ☐ None of the above
3. **In last 4 days, have you had close contact with anyone with flu symptoms** (fever, cough, sore throat)?
   ☐ No ☐ Yes
   Describe: _____
4. **Level of awareness:** ☐ Alert ☐ Confused ☐ Lethargic
   Oriented to: ☐ Person ☐ Time ☐ Place

ASSESSMENT

☐ **Inmate meets criteria for influenza-like illness (ILI).**
ILI is defined as: *temperature greater than* 100° F (37.8° C) *and presence of cough or sore throat.*

☐ **Asymptomatic inmate with history of close contact with someone with ILI**

☐ **Absence of influenza symptoms**

☐ **Other:** _____

PLAN

☐ No influenza-related restrictions

If clinical criteria for ILI met (see Assessment above):

☐ Provide inmate with face mask

☐ Transport inmate to Influenza Isolation Unit

☐ Educate inmate about: ☐ Use of mask ☐ Disposal of mask ☐ Cover cough/sneezes ☐ Hand washing

If history of recent ILI exposure:

☐ Quarantine in Influenza Quarantine Unit (for 4 days)

Date: Staff Signature & Stamp:	
Institution:	Patient Identification:

Attachment 1.4. Correctional Standard Precautions – General Population

The following precautions should be observed *routinely* by all correctional workers at all times to prevent spread of disease. *(General population* refers to all correctional settings except *health care settings*.)		
Component	**Indicated (X)**	**Recommendations**
Hand washing	X	Wash hands routinely with soap and running water for at least 15 seconds: before eating, after using the bathroom, when hands are dirty, and after contact with blood or other body fluids.
Respiratory hygiene	X	Cough/sneeze into sleeve or cover mouth/nose with tissue. Dispose of used tissues (in regular trash). Persons who are coughing or sneezing can use a paper mask to prevent spray. Wash hands after coughing or sneezing.
Safe practices	X	Avoid touching eyes, nose, and face. Germs are spread by touching your face.
Personal protective equipment (PPE)	Not routinely	Personal protective equipment is indicated only if contact with blood/body fluids is likely. PPE includes gloves to protect hands from contact; mask, face/eye wear, and gowns to protect from sprays and splashes.
Sharps	X	Dispose in a leak-proof, puncture-resistant container. Never recap, bend, break, or otherwise manipulate used needles.
Single cell	Not routinely	Place potentially infectious inmates in a private room (in consultation with medical staff). Consider single cells for inmates with poor hygiene practices.
Sanitation	X	Routinely clean with an EPA registered disinfectant (see (http://www.epa.gov/oppad001/chemregindex.htm). Use according to the manufacturer's instructions. All washable (non-porous) surfaces should be cleaned during and after (terminal) cell occupancy. Correctional workers should conduct sanitation inspections of living and bathroom areas to identify visibly dirty areas. Emphasize regular cleaning of surfaces that are frequently touched (hand-rails, elevator buttons, door knobs, computer key boards, etc.).
Laundry	X	Collect at bedside. If wet or soiled, handle as little as possible; bag in a leakproof bag at the location in which it was used, in accordance with local policy on management of linens. Machine wash and dry.
Activities (shared equipment)	X	Weight benches or any other surface exposed to sweat should be *disinfected daily*, and *routinely wiped clean between users* with a clean dry towel. Inmates should use barriers to bare skin, such as a towel or clean shirt, while using exercise equipment.
Report possible infections	X	Correctional workers who observe evidence of possible infections should report them promptly to their supervisor. Inmates with possible skin infections should be sent promptly for a medical evaluation.

Attachment 1.5. Correctional Standard Precautions – Health Care Settings

All workers in health care settings should observe the following precautions *routinely*.	
Components	**Recommendations**
Hand hygiene	*Hand hygiene is the most important measure to reduce transmission of infectious diseases.* Perform hand hygiene after touching blood or body fluids, after removing gloves, and between patient contacts. Hand hygiene includes handwashing with either plain or antimicrobial soap and water, as well as use of alcohol-based products (if approved by the warden). If hands are visibly soiled or contaminated, they should be washed with soap and water.
Respiratory etiquette	Educate staff, inmates, and visitors on the importance of containing respiratory secretions. Post signs with instruction on reporting influenza-like illness. Cough/sneeze into sleeve or cover mouth/nose with a tissue, disposing of used tissues in regular trash. Have persons who are coughing or sneezing use a paper mask to prevent spray. Hand hygiene after coughing/sneezing.
Personal protective equipment (PPE)	**Gloves:** For touching blood, body fluids, secretions, excretions, and contaminated items; for touching mucous membranes and nonintact skin. **Gown:** During procedures and patient-care activities where there is a possibility of contact of clothing/exposed skin with blood/body fluids, secretions, and excretions. **Face/eye protection** (e.g., face mask, goggles, or face shield)**:** During patient care activities likely to generate splash/spray of blood, body fluids, secretions, or excretions.
Safe work practices	Avoid touching eyes, nose, mouth, or exposed skin with contaminated hands (gloved or ungloved); avoid touching surfaces that are not directly related to patient care (e.g., door knobs, keys, light switches) with contaminated gloves and other personal protective equipment.
Patient resuscitation	Avoid unnecessary mouth-to-mouth contact. Use mouth piece, resuscitation, or other ventilation device to prevent contact with mouth and oral secretions.
Patient care equipment	Handle in manner that prevents transfer of microorganisms to oneself/others and to environmental surfaces. Wear gloves if visibly contaminated; perform hand hygiene.
Soiled linen & laundry	Handle in a manner that prevents transfer of microorganisms to oneself/others and to environmental surfaces. Wear gloves (and gown, if necessary) when handling and transporting soiled linen and laundry. Perform hand hygiene.
Needles & other sharps	Use devices with safety features when available; do not recap, bend, break, or manipulate used needles. If recapping is necessary, use a one-handed scoop technique; place used sharps in a puncture-resistant container.
Environmental cleaning & disinfection	Use EPA-registered hospital detergent disinfectant. Follow standard facility procedures for cleaning and disinfecting environmental surfaces. Emphasize cleaning/disinfection of frequently touched surfaces (e.g., bed rails, phones, lavatory surfaces). Change solutions regularly and clean the container to prevent contamination. Ensure patient care items and potentially contaminated surfaces are cleaned and disinfected after use. Use barrier-protective coverings, as appropriate, for surfaces that are touched frequently with gloved hands during patient care, that may become contaminated with blood/body fluids, or that are difficult to clean.
Disposal of solid waste	Contain and dispose of solid waste (medical and non-medical) in accordance with facility procedures and/or local or state regulations. Wear gloves when handling waste and when handling waste containers. Perform hand hygiene.

Attachment 1.6. Influenza Infection Control – General Population

The following guidelines are generally recommended *at all times* and should be emphasized during an influenza outbreak. *(General population* refers to all correctional settings except *health care settings*.)
Wash hands regularly and carefully!
• *Hand washing is the most important way to prevent transmission of the flu.* • Wash hands regularly with soap and water (before meals, after using the toilet, and after contact with blood or body fluids). • Wash for at least 15 seconds, in between fingers and on both sides of hands.
Cover mouth and nose when sneezing or coughing.
• Cough into sleeve or tissue. Dispose of tissues properly. • Wash hands after coughing or sneezing. • Place a face mask on an inmate who is repeatedly coughing or sneezing.
Avoid touching eyes, nose, and mouth.
• Surfaces can be contaminated with the flu virus (for example another person's hand or door knob). Touching such surfaces and then touching the eyes, nose, or mouth can lead to infection.
Clean environmental surfaces regularly, especially "high touch" surfaces.
• Use EPA approved disinfectants. • Emphasize cleaning frequently touched surfaces, such as door knobs, railings, light switches, and phones. • All washable (nonporous) surfaces should be cleaned during and after (terminal) cell occupancy. Correctional workers should conduct sanitation inspections of living and bathroom areas.
Handle laundry carefully.
• Wear gloves and protective clothing when handling soiled linen. • Wash hands afterwards. • Machine-wash in hot water and completely dry the laundry.
Wear gloves when touching blood or body fluids.
• Wear gloves whenever contact with blood, body fluids, or contaminated items is likely. Wash hands after removing gloves.
Report symptoms of the flu.
• Flu symptoms include fever, cough, shortness of breath, and sore throat. • Report to a supervisor if inmates or other employees develop flu symptoms.
Follow these procedures with flu patients.
• Inmates with flu symptoms should be given a face mask to wear. • Flu patients should be housed separately from other inmates.

Attachment 1.7. Pandemic Influenza Precautions – Health Care Settings

The following precautions should be used in conjunction with *Standard Precautions* (see *Attachment 1.5*) when in contact with *patients suspected of having pandemic influenza*.

Components	Recommendations
Hand hygiene	• **Hand hygiene is the number one defense.** Wash hands for 15–20 seconds. • Includes using plain or antimicrobial soap and water, or alcohol-based products. • Perform hand hygiene after touching blood/infectious body fluids, secretions, excretions, and contaminated items; after removing gloves; and in-between patients. • Use soap and water if hands are visibly soiled or have touched respiratory secretions. • Wash hands prior to putting on personal protective equipment (e.g., respirator or gloves), and after removing any protective devices. Avoid touching the outside of a contaminated device.
Safe work practices	• Avoid touching eyes, nose, mouth, or exposed skin with hands (gloved or ungloved). • Avoid touching surfaces (e.g., door knobs, keys, light switches) with contaminated gloves or other personal protective equipment that is directly related to patient care.
Respiratory etiquette	• Promote coughing or sneezing into one's sleeve or crook of elbow (rather than hands). • Provide tissues and no-touch (open) trash container.
Patient waiting areas	• Implement system to identify/triage inmates with influenza-like illness (ILI). • Spatially separate inmates with ILI from others. Place face mask on inmates with ILI.

Patient placement	• ***Influenza Isolation Units:***
	  • Isolate inmates with ILI in a private room or *cohort* groups of inmates with ILI in a specifically established, multi-bed unit.
	  • No special air handling is required. *Exception:* If aerosol-generating procedures are performed, an airborne-infection isolation (negative pressure) room is recommended.
	  • Post sign indicating "Influenza Isolation Unit" with appropriate PPE (*Attachment 1.10*).
	  • Depending upon how ill the inmates are, bunk beds may not be suitable.
	  • Keep the door closed. Ideally, have the bathroom attached to the room.
	  • Wear fit-tested respirator or face mask (based on Medical Director guidance) and gloves for touching contaminated surfaces. For additional PPE recommendations, see page 2 of this table.
	  • If feasible, have ILI patients wear a face mask when in close contact with workers.
	• ***Isolation Duration:*** Isolate until 24 hours after fever resolved. In Medical Referral Centers, isolate for 7 days after symptom onset or until symptoms resolved (whichever is longer).
	• ***Note:*** See 2nd page for recommendations about quarantine of inmates who are exposed to ILI.

Staffing	• Limit the number of caregivers per inmate. Ideally, staff caring for inmates with ILI are not assigned to take care of inmates with other (non-flu-related) health care problems. • Staff with symptoms of influenza-like illness should not come to work. • Asymptomatic health care workers who have had an unprotected exposure to an individual with ILI (at home or at work) should report their exposure to their supervisor. In general, exposed health care workers should not work with patients at high risk for influenza complications–for the 4 day period after exposure ended–unless they receive post-exposure antiviral prophylaxis.
Visits/social	• No visitation/social gatherings. Create as much distance as possible between people.
Patient transport	• Limit patient movement outside of the Influenza Isolation Unit to medically necessary purposes. • Have the patient wear a face mask (without an exhalation valve) when outside the unit. If mask can't be tolerated, apply most practical measures to contain respiratory secretions, e.g., handkerchief over nose/mouth, etc. • Patients should wash hands before leaving the unit and after a mask is removed.
Transport vehicles	• Transporters should wear a face mask or a fit-tested respirator (based on guidance from the Medical Director). Wash hands afterwards. • Optimize vehicle ventilation to increase the volume of air exchange during transport. • Routinely clean the vehicle with an EPA-disinfectant following the transport.

Attachment 1.7. Pandemic Influenza Precautions – Health Care Settings

Components	Recommendations
Personal Protective Equipment (PPE) for Influenza Isolation Units	
The PPE guidelines listed directly below apply only to Influenza Isolation Units, <u>not</u> Quarantine Units. ➔ **Careful placement of PPE *before* patient contact will avoid the need to make adjustments and risk self-contamination during use.**	

Respiratory Protection
The use of face masks vs. respirators in a pandemic will be based on guidance from the Medical Director.
	• ***Face masks or respirators (N-95 or higher filtering) should be worn when inside an Influenza Isolation Unit*** (based on guidance from the Medical Director).
	  • Respirators must be worn in the context of an OSHA Respiratory Protection Program (29 CFR 1910.034).
	  • Medical evaluation, training, and fit-testing of respirators are required prior to initial use.
	  • Respirators cannot be used with facial hair.
	  • Respirators are provided at no cost to the employee.
	• ***General guidance regarding respirator use:***
	  • Wash hands prior to donning and after removing mask or respirator.
	  • To reduce spread of germs, do not leave dangling around the neck.
	  • Respirators are not needed when using "food slot."
	  • Respirators should be disposed of if: the respirator becomes physically damaged; the integrity of the respirator is impaired; or the respirator becomes potentially contaminated during an aerosol generating procedure (e.g., nebulizer treatment or suctioning) or when in close contact with a patient who fails to cover a cough or sneeze. There is no need to dispose of respirator if merely walking through Influenza Isolation Unit, e.g., for census count.
	  • Respirators should be individually stored in a clean and dry container or plastic bag, stored to prevent damage to the respirator, and labeled with the name of the staff person to whom it is assigned. Otherwise the respirator should be disposed of at the end of a shift.
	• ***If respirators are in short supply***, they should be prioritized for situations associated with higher risk for transmission, e.g., aerosol-generating procedures (e.g., suctioning, nebulizer treatments); resuscitation of a patient; providing direct care to a patient with confirmed or suspected pneumonia who might produce larger-than-normal amounts of secretions when coughing.
	• ***If there is a significant shortage of respirators***, CDC indicates that face masks may be considered an alternative to respirators.

Gloves	Gloves should be worn for all interactions that may involve contact with the patient or potentially contaminated areas in the patient's environment. Gloves should be worn when picking up meal trays used by ill inmates. Wash hands after removing gloves.
Gowns & Eye Protection	Gowns and eye protection should be worn if spray or splash of body fluids (including respiratory secretions) is anticipated, i.e., suctioning or nebulizer treatments. Eye protection consists of appropriately fitted, indirectly vented goggles or a face shield. Eye glasses are not sufficient.
Guidelines for Influenza Quarantine Units	
Quarantine (ILI-exposed inmates with no symptoms)	• House inmates exposed to a person with suspected pandemic flu (no ILI symptoms) in a designated Influenza Quarantine Unit, with beds/cots 3–6 feet apart, as feasible. • Restrict contact with non-exposed persons. • If asymptomatic, release after 4 days (unless re-exposure occurs). • A face mask—not a respirator—is recommended when in close contact (within 6 feet). • Monitor for temperature and influenza signs and symptoms at least daily. • Quarantine may be unrealistic if pandemic influenza becomes widespread.

Attachment 1.8. Pandemic Flu Contact Investigation/Quarantine Procedures

When a case of influenza is identified, the following steps should be followed in conducting a contact investigation.

1) **Determine the infectious period** (from 24 hours before symptom onset until contact with the influenza case ended--usually the date the case was isolated).

2) **Identify closest contacts (cell mates, work-mates, friends) and other housing unit contacts.**

   For the purposes of this document, exposure is defined has having been in a setting where there was a high likelihood of contact with respiratory droplets and/or body fluids of a person with ILI. Examples of close contact include sharing eating or drinking utensils, or any other contact between persons likely to result in exposure to respiratory droplets. Close contact typically does not include activities such as walking by an infected person or sitting across from a symptomatic patient in a waiting room or office.

   Use *Attachment 1.9, Pandemic Flu Contact Investigation/Quarantine Line List* to list names of contacts and the outcome of their exposure.

3) **Screen contacts for temperature and cough or sore throat** recording results on the line-listing. Isolate any contacts who develop ILI symptoms.

4) **Decide which groups of contacts to quarantine.** There is no simple answer regarding who should be quarantined. Often the simplest measure is to quarantine the entire housing unit. If that is impractical, quarantine the inmates with the closest contact.

5) **Quarantine of exposed contacts should be maintained for 4 days after exposure ended (or the case was isolated).**

6) **Screen quarantined contacts daily for temperature and signs and symptoms (S/S), i.e., presence of cough or sore throat**, recording results on the quarantine line list.

7) A face mask should be worn in the quarantine room if close contact (within 6 feet) of quarantined inmates is anticipated. Face masks do not require fit-testing.

Note: If multiple influenza cases occur within multiple housing units, *a decision may be made to abandon contact investigations and quarantine as a control strategy*. In this case, everyone has become a contact and contact investigation is not a useful strategy.

Attachment 1.9. Pandemic Flu Contact Investigation/Quarantine Line List

Facility: ______ Staff Contact Name: _____________ Phone: __________ ILI Case Reg. No. ______

Index Case: Quarters: _______________ Work: _______________ Education: _______________
Recent Travel/Movement: _____________________ Case Symptom Onset Date: ___/___/___
Date ILI Case Isolated: ___/___/___ + 4 Days = ___/___/___ (date to discontinue quarantine)

#	Bed #	Last Name, First Name	Exposure Site (1–5)*	Date:**					Anti-vira Prophy?	Comments	Cleared (C) or Sick (S)
		Registration Number	Quarantine Date	Time:**					Start Date		Date
				Temp:					Y N		C S
				S/S?	Y N	Y N	Y N	Y N			
				Temp:					Y N		C S
				S/S?	Y N	Y N	Y N	Y N			
				Temp:					Y N		C S
				S/S?	Y N	Y N	Y N	Y N			
				Temp:					Y N		C S
				S/S?	Y N	Y N	Y N	Y N			
				Temp:					Y N		C S
				S/S?	Y N	Y N	Y N	Y N			
				Temp:					Y N		C S
				S/S?	Y N	Y N	Y N	Y N			
				Temp:					Y N		C S
				S/S?	Y N	Y N	Y N	Y N			
				Temp:					Y N		C S
				S/S?	Y N	Y N	Y N	Y N			
				Temp:					Y N		C S
				S/S?	Y N	Y N	Y N	Y N			
				Temp:					Y N		C S
				S/S?	Y N	Y N	Y N	Y N			
				Temp:					Y N		C S
				S/S?	Y N	Y N	Y N	Y N			
				Temp:					Y N		C S
				S/S?	Y N	Y N	Y N	Y N			
				Temp:					Y N		C S
				S/S?	Y N	Y N	Y N	Y N			
				Temp:					Y N		C S
				S/S?	Y N	Y N	Y N	Y N			

* (1) Quarters, (2) Work, (3) Education, (4) Travel, or (5) Other
**At the top of the chart, write the date and time that the contact's temperature and signs/symptoms (S/S) were checked. Use that column to record the contact's temperature and whether there were signs/symptoms of cough or sore throat.
For complete instructions on filling out this form, see page 2 of Attachment 1.9.

Note: This is an optional form that can be used to track the screening of individuals who are identified contacts to influenza case(s). If multiple influenza cases occur within multiple housing units, a decision may be made to abandon contact investigations and quarantine as a control strategy. In this case, everyone has become a contact, and contact investigation is not a useful strategy.

Page ___ of ___

Attachment 1.9. (Instructions)

The purpose of the optional ***Attachment 1.9***, ***Pandemic Flu Contact Investigation/Quarantine Line List,*** is to track the outcome for contacts exposed to a case of pandemic influenza. The form provides a record of exposure sites for a given index case with pandemic influenza and provides a place to record names of identified contacts. Space is provided to record daily temperatures and signs and symptom checks, as well as the outcome of the quarantine.

Facility: Facility code.

Staff Contact Name/Phone: Infection Control Officer (ICO) or designee, and phone number.

ILI Case Reg. No.: Registration number of the **index case**, the inmate who developed pandemic flu.

Quarters: Place(s) where the index case was housed, beginning one day prior to symptom onset until isolated.

Work: Index case's work assignment/group. If none, record "none."

Education: Index case's education classes/name of group. If none, record "none."

Recent Travel/Movement: Indicate locations if index case traveled or moved during infectious period.

Case Symptom Onset Date: Date flu symptoms started.

Date ILI Case Isolated: Date placed in isolation or cohorted.

+ 4 days: Determine the date that is 4 days after the case was isolated (to calculate the date that healthy contacts can be released from quarantine).

#: Assign each contact a sequential quarantine number.

Bed #: Bed assigned to the contact.

Last Name, First Name: Name of the inmate contact.

Registration Number: Registration number of the inmate contact.

Exposure Site: Use 1–5 to indicate site of exposure as (1) Quarters, (2) Work, (3) Education, (4) Travel, or (5) Other.

Quarantine Date: Date contact was quarantined.

Date and **Time:** At the top of the chart, record date and time that temperature and signs/symptoms were checked.

Temp and S/S?: Temperature and signs/symptoms for each date/time recorded at the top of the chart. Daily, record the inmate's temperature; indicate the presence of any signs or symptoms of cough or sore throat by circling **Y** (yes) or **N** (no). Use the **Comments** column to indicate type of flu symptom.

Antiviral Proph?: Antiviral Prophylaxis. Indicate if antiviral prophylaxis was provided to the contact, circling **Y** (yes) or **N** (no). If yes, indicate **Start Date**.

Comments: Record any comments about the quarantined inmate.

Cleared(C) or Sick (S): Indicate whether the patient is cleared after the 4-day quarantine period or becomes ill, by circling C (cleared) or S (sick). Indicate the **Date** that the person was either released from quarantine or was isolated due to illness.

Attachment 1.10. Precaution Signs for Influenza Isolation and Quarantine Units

The signs on the following two pages should be posted when utilizing a room for isolation or quarantine:

- **Influenza Isolation Unit** sign should be used for rooms housing one or more inmates with influenza-like illness.
- **Influenza Quarantine Unit** sign should be used for rooms housing asymptomatic inmates who have been exposed to ILI.

Influenza Isolation Unit

Housing for inmates with influenza-like illness—
to separate sick inmates from inmates who are well

PRECAUTIONS:

1. Use: ☐Respirator or ☐Face Mask

- N-95 or better
- Must be fit-tested

2. Use gloves:

- For direct patient contact or contact with contaminated items.

3. Use eye protection/gowns:

- If splash or spray of body fluids is anticipated, e.g., suctioning or nebulizer treatments.
- Eye protection requires either goggles or face shield.

4. Perform hand hygiene frequently:

- Always before entering and when leaving room.
- After removing gloves.

5. Discontinue isolation…

- 24 hours after temperature remains normal (without fever-reducing medication).
- ***For Medical Referral Centers only:*** Discontinue isolation 7 days after onset of symptoms or when symptoms are resolved, whichever is longer.

Influenza Quarantine Unit

Housing for asymptomatic inmates who have been exposed to influenza-like illness—to separate them from inmates who are either sick or have not been exposed

PRECAUTIONS:

1. Wear a face mask:

(not a respirator)

- Only if close contact with quarantined inmates (within 6 feet) is anticipated.
- No fit-testing is required.

2. Perform hand hygiene frequently:

- Always before entering and when leaving room.

3. Discontinue isolation…

- Isolation can be discontinued 4 days after the exposure to influenza-like illness ended, unless symptoms develop.
- If symptoms develop, isolate inmate in an *Influenza Isolation Unit*.

Federal Bureau of Prisons
Health Services Division

Pandemic Influenza Plan

Module 3:
Health Care Delivery

October 2012

BOP Pandemic Influenza Response Stages

The BOP *Pandemic Influenza Plan* is divided into the three stages that are used for standard BOP contingency plans; in this plan, the three stages are designed to correlate with the Federal Government Response Stages for pandemic influenza.

The BOP Pandemic Influenza Response Stages are as follows:

- **PREPARATION** (Federal Response Stages 0–1). Most of the detail in this plan involves the preparation phase.
- **RESPONSE** (Federal Response Stages 2–5). This phase, which begins when it is announced that there are confirmed human outbreaks overseas, involves both making last-minute preparations and actually responding to pandemic flu.
- **RECOVERY** (Federal Response Stage 6). This phase involves recovering from the pandemic, evaluating actions taken during the pandemic, and preparing for more flu. Based on what we know from previous pandemics, subsequent waves of flu are likely to follow once the pandemic flu has subsided.

Federal Government Response Stages*		BOP Influenza Plan	
		Federal Stages	BOP Stage
0	New domestic animal outbreak in at-risk country	**0-1**	**PREPARATION**
1	Suspected human outbreak overseas		
2	Confirmed human outbreak overseas	**2-5**	**RESPONSE**
3	Widespread human outbreaks in multiple locations overseas		
4	First human case in North America		
5	Spread throughout United States		
6	Recovery & preparation for subsequent waves	**6**	**RECOVERY**

**The Federal Government Response Stages should not be confused with the World Health Organization phases of pandemic influenza.*

Table of Contents

Overview

During pandemic flu, health care delivery may have to be altered to accommodate an increased number of inmates who are sick with the flu, and for shortages in personnel, equipment, and supplies. Standards of care that apply under normal circumstances may have to be modified. In the event of severe disruption, the allocation of scarce personnel, equipment, and supplies may have to be shifted to focus on saving the most number of lives possible—rather than the traditional focus on saving individual lives. ***Each facility should develop plans for health care delivery during pandemic flu, based on the relative degree of disruption to the prison health care system***.

Table A below provides a framework for how standards of care may shift during a pandemic, as the demand for health services increases and the ability of health care resources to respond is reduced.

Table A. Potential Alterations in Health Care Delivery—Based on Degree of Disruption Associated with Pandemic Flu

NORMAL CONDITIONS →	NORMAL STANDARDS OF CARE
• Normal resources and demands	• No change in standards of care
MILD DISRUPTION →	**NEAR-NORMAL STANDARDS OF CARE**
• Slightly reduced health care staffing • Some inmates ill; few severely ill • Community hospitalization available	**Possible adjustments include:** • Altered site of care for flu patients • Rearrange health care staffing/roles • Reduce preventive health care services (continue TB screening and influenza vaccination) • Maintain chronic care clinics • Provide care for minor ailments, as feasible
MODERATE DISRUPTION →	**REVISED MEDICAL CARE STANDARDS**
• Health care staffing somewhat reduced • Some shortages of supplies/medications • Limited laboratory capability • Many inmates ill; some severely ill • Limited community hospitalization available for sickest inmates	**Possible adjustments include:** • Prioritize delivery of chronic care • Minimize pill line; provide 4-6 week supply of chronic care pill line meds to some inmates • Eliminate most preventive health care except TB screening, influenza and pneumococcal vaccination • Focus on key life-saving care • Send severely ill to hospital • Eliminate care for low priority health problems
SEVERE DISRUPTION →	**TOTAL SYSTEM/STANDARDS ALTERATION**
• Health care staffing significantly reduced • Significant shortages supplies/medications • No lab capability; no chest radiography • Numerous inmates ill; many severely ill • No contract health care or subspecialists • No community hospitalization available	**Possible adjustments include:** • Focus on key life-saving care • Cohort sickest inmates/provide palliative care • Deliver care in accordance with priorities established by the BOP Medical Director

The degree of disruption caused by pandemic flu will be dictated in large part by how *infectious* the virus is (the flu attack rate) and the *virulence* of the virus (the death rate). In preparing for pandemic flu, planners in local facilities should review *Table B* below to assess the possible impact of pandemic flu on their facility: estimating the number of inmates who might become ill, based on *flu attack rates,* and the associated deaths, based on *death rates*.

Table B. Pandemic Influenza: Projected Number of Flu Cases and Flu-Related Deaths
(per 1000 inmates, based on flu attack rates and flu death rates)

Flu Attack Rate	Projected Flu Cases *(per 1000 inmates)*	Projected Flu-Related Deaths *(per 1000 inmates)* Death Rate Among Flu Victims:				
		1%	*2%*	*3%*	*4%*	*5%*
30%	300	3	6	9	12	15
40%	400	4	8	12	16	20
50%	500	5	10	15	20	25

BOP institutions are encouraged to review the issues identified below and start planning for health care delivery with pandemic flu.

Influenza Clinical Guidelines

Attachment 3.1 outlines clinical practice guidelines for pandemic flu. Facility clinicians should carefully review these guidelines and assess how they would be applied in this facility. Training should be provided on the clinical practice guidelines for health care staff in preparation for pandemic flu.

Prioritizing Care for Other Health Problems

With the increased demands posed by flu and the potential for reduction in health care resources, it may be necessary to prioritize health care for health care problems other than flu. In the event of pandemic flu, the Medical Director will issue specific guidance for prioritizing delivery of health care.

In preparation for pandemic flu, facilities should develop a means for rapidly identifying patients who require daily life-sustaining interventions or supervised medication. Included in the highest priority group are insulin dependent diabetics, renal dialysis patients and other seriously ill patients. Priority also should be given to inmates who, if untreated, would provide problems related to security, e.g., treatment of schizophrenics or those with other mental health problems; seizure disorders. It is also important to identify lower priority problems for which treatment or evaluation can be deferred.

Health Care Staffing

Current (or reduced) health care staffing levels may be inadequate to meet the demand both of routine health care and that created by a surge of flu cases. Alternative staffing plans should be developed to provide 12 to 24-hour coverage. Facilities should plan to supplement highly trained health care staff with non-health care staff.

In the event that 24-hour shifts become necessary, staff should be advised to bring changes of clothes, bedding, medications, etc., so they can be as comfortable as possible. There should be a place for staff to take rest breaks and provide a way for them to shower and do laundry.

Logistics

A practical approach to delivering care for hundreds of sick inmates must be developed by each facility. Outlined below are considerations when planning for pandemic flu.

- **Location:** Identify appropriate locations to house and care for large numbers of inmates who are sick with flu. Determine how and where sick inmates would be housed based upon different estimates for the percentage of inmates who are ill (i.e., 20%, 30%, 40%, 50%). Ideally these locations would be located adjacent to bathroom facilities. Possible locations include existing dormitories, gymnasium, or chapel. Bunk beds may or may not be suitable depending upon the how sick the inmates become.

- **Mattresses/Cots:** Mattresses can be placed either on cots (ideally) or on the floor. However, it is important to devise some method to elevate the head of the bed to facilitate breathing. Given that flu patients may suffer from vomiting, diarrhea and incontinence, some method should be devised to assure that mattresses are impervious (either existing plastic covers or covering the mattresses with plastic bags).

- **Linens:** At least two sets of sheets will be needed for each sick inmate with plans for laundering them. Towels, wash cloths or rags will be needed for cleaning and drying.

- **Other:** Anticipate the need for bedpans and urinals. Develop plan for disposing of human waste. Plan for something to use as emesis basins, e.g., paper bags lined with plastic bags (for easy disposal of waste). *Attachment 3.2* lists other supplies to consider for stockpiling.

Organization of Health Care Delivery

Consider methods to most efficiently delivery health care during pandemic flu, including altered roles for staff and how to organize care for large numbers of inmates. During pandemic flu "lock-down" may be utilized for social distancing. Strategies should be developed to overcome the significant obstacles posed by "lock-down" for health care delivery. Pill lines may need to be suspended (except for controlled substances and those likely to destabilize the security of the institution, e.g., quetiapine). To facilitate medication delivery, certain groups of inmates may need to be cohorted, e.g., insulin dependent diabetics.

Action Steps by Pandemic Stage

Preparation (Federal Response Stages 0–1)
(See *Standard Operating Procedures*, which are provided for the Preparation stage only.)

1. Identify staff persons responsible for planning for and directing health care delivery during pandemic influenza.
2. Review *Attachment 3.1*. *BOP Pandemic Influenza Clinical Practice Guidelines* and assure training of clinical staff.
3. Calculate estimates of the number of ill inmates in your facility based on the percentage who become ill.
4. Identify high and low priority health care delivery functions.
5. Develop plans for augmenting health care staffing during pandemic flu (12 to 24-hour staffing, use of non-health care staff.
6. Develop plans for "Influenza Isolation Room" wards to accommodate up to 20%, 30%, 40%, and 50% of the inmate population.
7. Develop plan for increasing par levels of medical and related supplies with pandemic flu.
8. Develop plan for increasing par levels of pharmaceuticals with pandemic flu.
9. Develop facility-specific plan for health care delivery during pandemic flu.

Response (Federal Response Stages 2–5)

Begin when there are confirmed human outbreaks of pandemic flu anywhere in the world:

1. Reach par levels for medications and supplies.
2. Providing training updates to non-health care staff to assist in caring for inmates with pandemic flu.
3. Prepare and stock temporary exam rooms in areas identified.

Begin after a suspected pandemic influenza case is diagnosed in the facility:

4. Adjust staffing schedules as needed to accommodate for health care staffing shortages.
5. On an ongoing basis assess the capability of health services to provide medical care. As needed, triage and prioritize provision of care. If necessary, suspend most preventive health care services except TB screening, and influenza and pneumococcal vaccination.

(continued on next page)

6. Treat acute influenza cases in ward setting. Reorganize health care delivery to increase efficiency.

- **a.** Implement clinical guidelines for flu with emphasis on:
  - maintaining adequate hydration
  - treating high priority flu patients with antivirals per CDC priority groups
  - treating suspected secondary pneumonia with antibiotics
- **b.** Inmates with a CRB-65 Score of 3 to 5 should be hospitalized (if community resource is available). Inmates with a CRB-65 Score of 2 should be considered for hospitalization. See *Attachment 3.1, BOP Pandemic Influenza Clinical Practice Guidelines.*
- **c.** Assess availability of resources such as community hospitalization, laboratory testing, chest radiography and ventilatory support.

7. If decision is made to lock down:

- **a.** Consider suspending pill lines and issuing safe and reasonable quantities of pill line medications (except for controlled substances and medications likely to destabilize the security of the institution).
- **b.** Insulin will still have to be administered because it has to be refrigerated and requires needle and syringe. Consider clustering inmates on insulin.

Recovery (Federal Response Stage 6)

Previous flu pandemics have been associated with subsequent "waves" of flu after an initial wave resolves. After an initial pandemic flu outbreak, subsequent outbreaks are likely. The recovery period will involve both recovering from the pandemic emergency, evaluating the BOP response to it and preparing for subsequent waves of pandemic flu.

1. Begin discharge of inmates from isolation wards.

2. Initiate terminal cleaning procedures for quarantine areas.

3. Resume normal operations of the Health Services Unit.

4. Prepare for secondary / tertiary waves of pandemic flu.

5. Return to normal staffing schedules. Provide additional time off, if possible.

6. Evaluate delivery of health services during pandemic flu.

7. Write a summary report, identifying recommendations for future waves of the pandemic for the Regional and Central Office.

Module 3: Health Care Delivery
Standard Operating Procedures for Preparation Stage
(Federal Response Stages 0–1)

During the Preparation stage, adapt this Standard Operating Procedure template to the unique circumstances of your facility. A modifiable Word version is posted on: www.bop.gov/news/medresources.jsp.

1. Identify staff persons responsible for planning for and directing health care delivery during pandemic influenza.

The staff person assigned is:
An alternate staff person is:

2. Review *Attachment 3.1, BOP Pandemic Influenza Clinical Practice Guidelines,* and assure training of clinical staff.

The following plan will be followed to assure that staff are updated on the *Pandemic Flu Clinical Practice Guidelines*:

3. Calculate estimates of the number of ill inmates in your facility based on the percentage who become ill.

Multiply "multiplier" by the "# inmates in facility" to calculate projected number ill:

Percent ill	Multiplier	# inmates in facility	Projected # ill
20%	0.2		
30%	0.3		
40%	0.4		
50%	0.5		

4. Identify high and low priority health care delivery functions.

a. Identify categories of inmate health problems that will require ongoing care during a pandemic emergency and the current number of inmates who fall into each category.

Indicate the illnesses that are high priority for ongoing health care and the number of inmates who fall into each category: insulin dependent diabetes (___), renal dialysis (___), ...

The following illnesses are high priority for security reasons: schizophrenia (___), seizure disorders (___), ...

b. Identify categories of health problems and health services that are low priority and non-essential that could be eliminated with pandemic flu.

c. In a pandemic emergency, inmates with high priority medical problems will be identified rapidly as follows:

5. Develop plans for augmenting health care staffing during pandemic flu.
a. Develop alternative plans for 12- to 24-hour staffing and describe here:
b. Develop list of health care functions that can be performed by non-licensed individuals.
c. Identify non-health care staff with health care experience who might be utilized during pandemic flu.
6. Develop plans for "isolation" wards to accommodate up to 20%, 30%, 40%, and 50% of the inmate population.
a. Identify locations where care can be provided to large numbers (ideally adjacent to toilet facilities), e.g., gymnasium, chapel, existing dormitories. Bunk beds may not be appropriate, depending upon illness severity.
b. Identify what will be utilized for beds (cots or mattresses on floor).
c. Identify method to elevate the heads of the mattresses.
d. Assure that mattresses utilized can have impervious cover, e.g., existing plastic covering, large plastic trash bags.
7. Develop plan for increasing par levels of medical and related supplies.
Referencing *Attachment 3.2, Medical Supply List for Pandemic Flu,* develop and implement facility-specific plan for increasing par levels of certain medical supplies as follows:
8. Develop plan for increasing par levels of pharmaceuticals with pandemic flu.
Referencing *Attachment 3.3, Non-Prescription and Prescription Drugs for Pandemic Flu,* develop and implement facility specific plan for increasing par levels of certain over-the-counter and prescription drugs for treating flu and other chronic illnesses as follows:
9. Develop facility-specific plan for health care delivery during pandemic flu.
Address reassignment of health care roles, flow of health care delivery, clustering of sickest inmates, methods for overcoming inefficiencies posed by "lock-downs," documentation, etc.

Attachments

Attachment 3.1: BOP Pandemic Influenza Clinical Practice Guidelines

Attachment 3.2: Medical Supply List for Pandemic Flu

Attachment 3.3: Non-Prescription and Prescription Drugs for Pandemic Flu

Attachment 3.4: Oral Rehydration Solution (ORS)

Attachment 3.1. BOP Pandemic Influenza Clinical Practice Guidelines

This *Pandemic Influenza Clinical Practice Guideline* is made available to the public for informational purposes only. The Federal Bureau of Prisons (BOP) does not warrant these guidelines for any other purpose, and assumes no responsibility for any injury or damage resulting from the reliance thereof. Proper medical practice necessitates that all cases are evaluated on an individual basis and that treatment decisions are patient specific. Consult the BOP Clinical Practice Guideline Web page to determine the date of the most recent update to this document: *http://www.bop.gov/news/medresources.jsp*.

References

These guidelines are adapted from:

(1) Department of Health and Human Services, Pandemic Influenza Plan, Supplement 5 Clinical Guidelines (December 2, 2005). Available from*:* *http://www.hhs.gov/pandemicflu/plan/#part2* and

(2) British Thoracic Society. Guidelines for the clinical management of patients with an influenza-like illness during an influenza pandemic (January 2007). Available from: *http://www.brit-thoracic.org.uk/Portals/0/Clinical%20Information/Influenza/Guidelines/pandemicflupdf07.pdf*

(3) Infectious Disease Society of America. Seasonal influenza in adults and children—diagnosis, treatment, chemoprophylaxis, and institutional outbreak management: clinical practice guidelines of the Infectious Diseases Society of America. CID 2009;48:1003-1032. Available from*:* *http://www.idsociety.org/Content.aspx?id=9088*

Contents

The following guidelines are based upon experience with seasonal influenza, as well as reports on previous occurrences of pandemic influenza. The manifestations of pandemic influenza cannot be fully predicted.

1. Clinical Diagnosis

Laboratory testing for influenza is primarily a surveillance tool used to determine whether or not the respiratory illness that is being seen is in fact influenza. After it has been determined that influenza is circulating, a clinical definition for influenza is generally utilized. The clinical manifestations of infection by influenza viruses are diverse, ranging from asymptomatic infection to fulminant respiratory distress leading to respiratory failure and death.

The three-fold combination of *fever*, *cough*, and *acute onset of symptoms* are the most predictive clinical features. Importantly, the predictive value of a clinical definition of influenza-like illness (ILI) increases significantly when they occur in the context of *influenza circulating in the community.*

BOP Influenza-Like Illness (ILI) Clinical Case Definition:

Fever (temperature of 100^{o} F [37.8^{o} C]) plus either cough or sore throat—in the absence of a known cause other than influenza.

2. Clinical Features of Uncomplicated Influenza

The range of symptoms associated with uncomplicated influenza infection are summarized in Table 1. *Fever* is the paramount symptom and may reach 41° C although more usually it ranges between 38-40° C. The peak occurs within 24 hours of onset and lasts typically for 3 days (range 1–5 days). The *cough* is generally dry, but in 40% of cases it may be productive. A productive cough together with chest tightness and substernal soreness is more common in patients with underlying chronic lung disease. *Myalgia* affects mainly the back and limbs.

Table 1. Range of Symptoms Associated with Uncomplicated Seasonal Influenza Infection

Fever (~100%)	Headache (~65%)	Sore throat (~50%)
Cough (~85%)	Anorexia (~60%)	Gastrointestinal symptoms (<10%)
Malaise (~80%)	Rhinorrhea (~60%)	
Chills (~70%)	Myalgia (~53%)	

Clinical findings include a toxic appearance in the initial stages, hot and moist skin, a flushed face, and injected eyes. Tender cervical lymphadenopathy is found rarely (~10%). In uncomplicated infection, the illness usually resolves in seven days. However, cough, malaise and lassitude may persist for weeks. The spectrum of clinical disease associated with a pandemic strain cannot be predicted.

3. Complications of Influenza

Influenza virus infection has been associated with worsening of certain clinical conditions, i.e., heart failure, diabetes, coronary heart disease, asthma, and chronic obstructive pulmonary disease. Individuals in the following risk groups have a higher risk of developing complications to seasonal influenza.

Table 2. Persons at High Risk for Influenza Complications

- **Pregnant women or post-partum women within 2 weeks of delivery**
- **Adults 65 years of age or older**
- **Persons with the following medical conditions:**
  - Chronic pulmonary disorders (including asthma) (should generally be treated with Tamiflu)
  - Cardiovascular disorders (except hypertension)
  - Renal disorders
  - Hepatic disorders
  - Hematological disorders (including sickle cell anemia)
  - Neurologic disorders (including disorders of the brain, spinal cord, peripheral nerve, and muscles— such as cerebral palsy, epilepsy, stroke, intellectual disability, moderate to severe developmental delay, muscular dystrophy, or spinal cord injury)
  - Cognitive disorders (e.g., serious mental health disorders)
  - Neuromuscular disorders
  - Metabolic disorders (including diabetes mellitus)
  - Immunosuppression, including that caused by medications or HIV
  - Morbid obesity (BMI $\geq$ 40)

In addition, there are specific complications associated with influenza infection, regardless of existing medical conditions, listed below.

Respiratory

- ***Acute bronchitis*** is common, more often occurring in the elderly and those with chronic medical conditions.
- ***Primary viral pneumonia*** is uncommon in seasonal flu, but was a frequent occurrence in the 1918-19 pandemic flu, particularly among young adults.
- ***Secondary bacterial pneumonia*** occurs frequently, typically 4–5 days after illness onset.

Cardiovascular

ECG abnormalities are common, usually with no cardiac symptoms. These include non-specific T wave and rhythm changes and ST segment deviation. Myocarditis and pericarditis both are rare complications.

Central Nervous System

CNS complications rarely occur. These include encephalitis/ encephalopathy (which generally occurs in the first week of illness) and transverse myelitis and Guillain-Barre syndrome which are both very rare.

Other complications include otitis media (common in children). Very rarely toxic shock syndrome and parotitis occur.

4. Influenza-Related Pneumonia

The incidence of pneumonia complicating influenza infection varies widely, from 2% to 38%, depending on viral and host factors. Pneumonia generally occurs more frequently and with greater severity in patients with preexisting chronic cardiac and respiratory conditions.

In the context of an influenza pandemic, the presence of an ILI and new or worsening dyspnea should prompt a careful examination for presence of complicating pneumonia. Two main types of influenza-related pneumonia are recognized: primary viral pneumonia and secondary bacterial pneumonia.

Primary Viral Pneumonia

Primary influenza viral pneumonia has been a prominent feature of previous influenza pandemics, but is a relatively rare outcome of seasonal influenza in adults.

- ***Onset:*** Typically become breathless within the first 48 hours of the onset of fever. An initially dry cough may become productive of blood-stained sputum. Presence of cyanosis and/or tachypnea.
- ***Chest auscultation:*** Bilateral crepitations and wheeze are usual.
- ***Chest x-ray:*** Most commonly bilateral interstitial infiltrates in the mid-zones.
- ***Mortality:*** Rapid clinical deterioration with respiratory failure may ensue. The mortality rate in hospitalized patients is high (>40%) even with maximum supportive treatment.

Secondary Bacterial Pneumonia

With *seasonal flu,* bacterial pneumonia occurs approximately 4 times more often than viral pneumonia.

- ***Chest auscultation:*** rales, rhonchi, diminished breath sounds.
- ***Chest x-ray:*** usually demonstrates a lobar pattern of consolidation.
- ***Common etiologies:*** *Streptococcus pneumoniae, Staphylococcus aureus,* group A Streptococcus, and *Haemophilus influenzae.*
- ***Mortality:*** Mortality rate ranges from 7–24%.

Mixed Viral-Bacterial Pneumonia

Bacterial and viral pneumonia can occur concurrently. Chest radiograph may demonstrate lobar consolidation superimposed on bilateral diffuse lung infiltrates. Mortality is similar to that for primary viral pneumonia (>40%).

5. Clinical Management of Influenza

a. Patient Education and Symptomatic Treatment

All inmates presenting with symptoms suggestive of influenza (except those for whom urgent admission is required) should be given general advice on symptomatic treatment, be provided information about the illness and address individual concerns. Key messages are outlined below in *Table 3*:

Table 3. Key Patient Education Messages – Pandemic Influenza

- The incubation period (time period from exposure to development of symptoms) is typically 1–4 days.
- Infected adults are presumed to be contagious from one day before symptoms until 24 hours after temperature is normal (without fever-reducing medications). However, patients should be very careful to continue to cover their cough and wash hands frequently for a few days after that.
- Fever usually declines after 2–3 days and normally disappears by the sixth day of illness.
- Cough, weakness and fatigue can persist for 1–2 weeks and up to 6 weeks.
- Antibiotics do not benefit most people with influenza but are sometimes needed to treat secondary infections.
- Generally recommended symptomatic treatment for influenza includes:
  - Treat fever, myalgias, and headache with acetaminophen or ibuprofen.
  - Rest.
  - Drink plenty of fluids.
- Inmates should promptly report occurrence of shortness of breath and worsening of symptoms after initial improvement.

b. Patient Assessment

General daily assessment of inmates with influenza-like illness (ILI) should include:

- Observation of level of awareness (presence of lethargy, confusion, disorientation).
- Observation of hydration status (dry, sticky mouth; thirst; decreased {dark} urine output; headache; dizziness). Hydration is critically important. All staff should be alert to signs of dehydration and offer flu patients fluids every hour or two, as needed. A recipe for oral rehydration solution is provided in *Attachment 3.4*.
- Vital signs (temperature, pulse, respirations, blood pressure), if indicated.

The following groups of inmates with ILI should be considered for closer nursing/clinician observation:

- Cognitively impaired.
- Mentally ill (particularly those on psychotropic medications).
- Chronically ill inmates (e.g., diabetes, chronic respiratory illness, immunocompromised, etc.).
- Those exhibiting signs and symptoms of deteriorating clinical status (see *Table 4* below).

Table 4. Influenza Signs and Symptoms Meriting Clinical Evaluation

• **Signs of dehydration**
  • Low blood pressure/rapid heart rate
  • Orthostatic hypotension (BP that drops when going from lying down to standing)
  • Poor skin turgor (skin lacks normal elasticity and sags back into position slowly when pinched up into a fold)
  • Delayed capillary refill
  • Shock
• **Signs of respiratory distress** (perform pulse oximetry, if available)
  • Respiratory rate >30/min
  • Shortness of breath at rest or while doing very little
  • Painful or difficulty breathing
  • Blood in sputum
• **Changes in level of awareness**
  • Drowsiness
  • Disorientation
  • Confusion
• **Fever for 4–5 days which does not improve** (or gets worse)
• **Clinical improvement and then develops high fever** and feels poorly again (consider bacterial pneumonia)
• **Lack of improvement after two days of antiviral drugs**

c. Triage

In the event of pandemic flu, there is likely to be a significantly increased number of inmates seeking consultation. Barriers to care should be removed, e.g., eliminating co-pays for clinic visits for flu symptoms.

Decisions regarding clinical management of patients with influenza should be based primarily on an assessment of the illness severity; identification of whether or not the person is in an "at risk" group (see *Table 2*); availability of community hospitalization resources, and current recommendations of the CDC and the BOP Medical Director.

d. Criteria for Hospital Referral

Most adults with uncomplicated influenza infection do not require hospital referral. Patients who might require hospital admission fall into two main groups: those with worsening of a pre-existing clinical condition and those with an influenza-related complication.

- ***Worsening of pre-existing medical condition:*** Patients with clinical deterioration of a preexisting medical condition should be managed according to best practice for the medical condition in question.
- ***Influenza-related pneumonia:*** The most common influenza-related complication requiring hospital admission is pneumonia. Patients who complain of new or worsening dyspnea should be carefully assessed for signs of pneumonia. If pneumonia is diagnosed, disease severity should be assessed.

For pandemic flu, it is recommended that a validated severity assessment tool be utilized to assess disease severity and need for hospital referral. The CRB-65 score (see *Table 5* below) is a well-validated severity assessment tool developed for patients with community acquired pneumonia. *However, this system has not been validated for influenza-related pneumonia. It should be used as a supplement and not replace the judgment of the individual clinician*.

Table 5. CRB-65[1] Severity Scoring Tool (for use with pandemic influenza)	
CLINICAL FACTORS	**POINTS**
Confusion	1
Respiratory Rate >30 per minute	1
Systolic BP <90 mm Hg *or* Diastolic BP ≤69 mm Hg	1
Age ≥65	1
CRB-65 SCORE (TOTAL):	
[1] *CRB-65= Confusion, Respiratory Rate, Blood Pressure, 65 years of age or older*	

Table 6 outlines recommendations based on a patient's CRB-65 score.

Table 6. Recommendations Based on CRB-65 Scores[2]		
CRB-65 SCORE	**RECOMMENDED ACTION**	**DEATH RATE**
0	Likely suitable for treatment in facility	0.9%
1	Consider hospital referral, particularly with a score of "2"	5.2%
2		12.0%
3 or 4	Urgent hospital referral	31.2%
Any score, with bilateral chest signs of pneumonia	Consider hospital referral	
[2] *Adapted from: British Thoracic Society. Guidelines for the clinical management of patients with an influenza-like illness during an influenza pandemic (January 2007)*		

In the event that community hospitalization is unavailable, BOP facilities should develop plans for congregating severely ill inmates for provision of care, including if necessary, palliative care.

e. Use of Antiviral Medication

See *Module 2, Antiviral Medication and Vaccines,* for a more thorough discussion of antiviral medications. The following guidelines should be followed when administering antiviral medication.

- ***Antiviral medication should be offered as treatment only to inmates with risk factors for influenza complication (see Table 2) who have:***
  - Acute influenza-like illness ***and***
  - Fever (≥ 100° F [37.8 C])

  In general, antiviral medication is administered only to those with symptom onset occurring in the previous 48 hours. However, antiviral therapy should be administered after 48 hours for pregnant women and anyone with severe illness.

- ***Potential benefits of antiviral treatment include:***
  - A reduction of illness duration by 24 hours
  - A possible reduction in hospitalization
  - A reduction in subsequent antibiotic use

- ***Recommended antiviral treatment:*** Utilize *Attachment 2.2. Antiviral Medication—Medical Evaluation, Consent, and Prescribing Form* found in *Module 2, Antiviral Medications and Vaccines*.

  Two antiviral medications are options for treating influenza: Oseltamivir (Tamiflu®) and Zanamivir (Relenza®). Zanamivir is an inhaled medication and may be inappropriate for individuals with underlying respiratory disease. Dosing of these medications is as follows:

  - **Oseltamivir:** 75 mg twice daily for five days. For patients with renal function impairment (creatinine clearance between 10–30 ml/min), the dose is 75 mg *once daily* for five days.
  - **Zanamivir:** Two 5 mg inhalations (10 mg total) twice per day for five days.

f. Use of Antibiotics

The use of antibiotics in adults with influenza not complicated by pneumonia is determined by the presence of any co-morbid illnesses and the timing of symptom onset.

- ***Patients without severe pre-existing illnesses:*** Features of an acute bronchitis, with cough, retrosternal discomfort, wheeze, and sputum production are an integral part of the influenza. In previously well individuals who do not have pneumonia or new focal chest signs, antibiotics are *not* indicated. If the patient is seen later in the course of the illness and the illness is worsening, i.e., reoccurring fever or increasing breathlessness, then a worsening bacterial bronchitis or developing pneumonia is possible and the use of antibiotics should be considered.
- ***Patients with severe pre-existing illness:*** Those at high risk of influenza-related complications of either COPD or other severe co-morbid disease should be strongly considered for antibiotics. If the patient does not begin to improve over the next 48 hours after starting an antibiotic they should be assessed for pneumonia.
- ***Patients with influenza-related pneumonia:*** Patients should be assessed for severity of illness and, if needed, referred for inpatient hospitalization utilizing the CRB-65 Score (see Table 5). All patients with suspected pneumonia should be treated with antibiotics.

Antibiotics should cover the likely bacterial pathogens including *Streptococcus pneumoniae, H. influenzae,* and *Staphylococcus aureus,* including MRSA (in the context of endemic MRSA transmission in a facility).

Attachment 3.2. Medical Supply List for Pandemic Flu

Each facility should consider the list of supplies below and determine the degree to which par levels should be increased.

Beds, mattresses, and linens

- Cots with mattresses (or mattresses placed on floor)
- Impervious cover for mattresses (if needed), i.e., large plastic bags
- Mechanism to elevate head of bed (e.g., rolled towels, other creative ideas)
- Linens (need enough to change linen on average once or twice a day) with plan for laundering
- Towels, wash cloths, rags

Medical supplies

- Electronic thermometers
- Thermometer covers
- Automatic blood pressure cuffs
- Extra stethoscopes (to stay in each room)
- Bed pans/urinals
- Emesis basins (or paper bags lined with plastic bags for easy disposal)

Other supplies

- Plastic cups
- Flexible drinking straws
- Disposable dishes
- Plastic bags of all sizes (always useful)
- Heavy duty rubber bands (to close plastic bags)
- Duct tape (always useful)
- EPA registered disinfectant
- Clipboard, pens, charting forms

Oral rehydration solution (ORS) ingredients

- Salt
- Sugar
- Baggies — to pre-mix sugar/salt mixture
- One-gallon (new) containers for storing oral rehydration solution

Attachment 3.3. Non-Prescription and Prescription Drugs for Pandemic Flu

Each facility should consider the list of drugs below and develop a plan for increasing par levels.

Over-the-counter medications (for treating influenza patients)

Each institution pharmacy should attempt to increase stock in the pharmacy to accommodate a prescription distribution based upon a 15% attack rate. These include:

- Ibuprofen
- Acetaminophen
- Aspirin
- Loperamide

Additionally, it is suggested that the institution health services staff work with their local commissary to look at the possibility of increasing commissary par levels for cough syrup/drops and antihistamines.

Prescription drugs (for treating influenza patients)

- Oseltamivir (Tamiflu®) — antiviral stockpile quotas communicated by memo
- Zanamivir (Relenza®) — antiviral stockpile quotas communicated by memo
- Antibiotics:
  - Doxycycline 100 mg
  - Amoxicillin-clavulanate 500mg/125mg
  - Erythromycin 500 mg
  - Clarithromycin 500 mg
- Albuterol or other bronchodilator

Prescription drugs (critical chronic care medications)

As normal medication supply channels may be disrupted during a pandemic outbreak, institutions should consider increasing stocks of chronic care medications in order to maintain adequate supplies.

Attachment 3.4. Oral Rehydration Solution (ORS)

Prevention and treatment of dehydration associated with influenza may be the most important life saving measure available. Oral rehydration solution (ORS) is an effective treatment for all causes of dehydration. It consists of uncontaminated water and specified amounts of salt and sugar.

Signs and symptoms of dehydration include:

- Dry mouth
- Increased pulse (>90/minute),
- Poor skin turgor (doesn't bounce back when pinched),
- Decreased urine output
- Dark urine

If dehydration is suspected, administer ORS by mouth:

- Use of a bendable straw may be helpful.
- If the patient is too ill to drink, someone must sit with them and administer the fluids using a teaspoon.
- *Usual treatment consists of 3 quarts (or 13 cups of fluid) per day.*

Signs of ORS "working" include:

- Increased alertness of patients
- Increased urination

Continue to push ORS. Once the patient is well-hydrated, the patient can be switched to other clear fluids such as juice, clear soup, or tea; then graduate to crackers, toast; then to other food.

Oral Rehydration Solution "Recipe":

The recipe for ORS should be followed closely to get the right proportion of salt and water. The solution can be flavored with sugar-free drink mix.

Oral Rehydration Solution (ORS) Recipe
1 gallon of uncontaminated water
10 tablespoons sugar
4 teaspoons salt
Directions: Stir up. Do not boil. Can add sugar-free drink mix to flavor. Use within 24 hours.
Reference: Rehydration Project (homepage on the internet): rehydrate.org/solutions/homemade.htm (extrapolated from recipe of 1 liter water, 8 tsp sugar, 1 tsp salt)

U.S. Department of Justice
Federal Bureau of Prisons

FOR IMMEDIATE RELEASE
March 24, 2020

Contact: Office of Public Affairs
202-514-6551

Bureau of Prisons Update on COVID-19

WASHINGTON -- In response to the COVID-19 pandemic, the Bureau of Prisons (Bureau) is taking aggressive steps to protect the safety and security of all staff, and inmates, as well as visitors and members of the public. This response is the Bureau's top priority. Director Michael Carvajal has directed the Bureau to take a comprehensive approach to the COVID-19 pandemic.

On March 13, 2020, the Bureau instituted significant measures to prevent the COVID-19 virus from spreading in its facilities. These measures include temporary restrictions on visitation, restricting inmate movement to only required and mission-essential transfers, increased health screening of staff and inmates, and increased sanitary measures. In addition, all Bureau facilities have been directed to designate available space for isolation and quarantine for inmates who have been exposed to or have symptoms of the virus.

The Bureau has also instituted a mandatory 14-day quarantine for all new inmates entering the Bureau from outside a Bureau facility. The Bureau is actively working with the US Marshals Service, the federal courts, and State and local correctional institutions to mitigate the risk of exposure in pre-trial detention and jail facilities and to maximize the safe transfer of inmates into Bureau custody.

The Bureau is also working with the courts and the US Marshals Service to reduce transmission risks from movement for court proceedings, with options such as the use of video conferencing.

The Bureau is proud to serve the public in concert with its other law enforcement partners, as we work to mitigate the risk of COVID-19 to staff, inmates, and the public.

The Bureau's Actions to Address the COVID-19 Threat:

Since January 2020, the Bureau has implemented its approved Pandemic Influenza contingency plan, modified for COVID-19. The Bureau has been coordinating its COVID-19 efforts using subject-matter experts and guidance from the Office of the Vice President, the World Health Organization (WHO), the Centers for Disease Control (CDC), and the Office of Personnel Management (OPM). The Bureau has proceeded in three phases:

Phase 1: In January 2020, the Bureau established a task force to begin strategic planning for COVID-19, and to build on the Bureau's already existing procedures for pandemics.

Phase 2: On March 13, 2020, the agency issued directives suspending social and legal visits, curtailing movement, cancelling staff travel and training, limiting access for contractors and volunteers, and established enhanced screening for staff and inmates for locations with sustained community transmission and at all medical centers. All facilities were placed on modified operations to maximize social distancing in our facilities, as much as practicable. This modification includes staggered meal times and staggered recreation times, for example, in order to limit congregate gatherings Additionally, the Bureau established quarantine and isolation procedures to mitigate the spread of COVID-19.

Phase 3: On March 18, 2020, the Bureau implemented an action plan for Bureau locations that perform administrative services, which followed DOJ, OMB and OPM guidance for maximizing telework. Additionally, as part of the Pandemic Influenza contingency plan, all cleaning, sanitation, and medical supplies have been inventoried. Ample supplies are on hand and ready to be distributed or moved to any facility as deemed necessary. As we continue to respond, the Bureau has placed additional orders for these supplies, in case of a protracted event.

The Bureau will continue to provide daily updates and information on actions related to COVID-19 at www.bop.gov/coronavirus/index.jsp

###

COVID-19 Action Plan: Phase Five

Additional Agency-wide Actions Effective April 1

Updated 6:30 PM ET, March 31, 2020

(BOP) - Today, the Director of the Bureau of Prisons (BOP) ordered the implementation of Phase 5 of its COVID-19 Action Plan, effective tomorrow, April 1, 2020 In response to a growing number of quarantine and isolation cases in our facilities, the BOP will take the following actions immediately to further mitigate the exposure and spread of COVID-19

- For a 14-day period, inmates in every institution will be secured in their assigned cells/quarters to decrease the spread of the virus This modification to our action plan is based on health concerns, not disruptive inmate behavior
- During this time, to the extent practicable, inmates should still have access to programs and services that are offered under normal operating procedures, such as mental health treatment and education
- In addition, the Bureau is coordinating with the United States Marshals Service (USMS) to significantly decrease incoming movement during this time
- After 14 days, this decision will be reevaluated and a decision made as to whether or not to return to modified operations
- Limited group gathering will be afforded to the extent practical to facilitate commissary, laundry, showers, telephone, and Trust Fund Limited Inmate Computer System (TRULINCS) access

Starting in January 2020, the BOP implemented its Pandemic Influenza contingency plan, modified as an Action Plan for COVID-19 The BOP continues to revise and update its action plan in response to the fluid nature of the COVID-19 pandemic, and in response to the latest guidance from experts at the World Health Organization (WHO), the Centers for Disease Control and Prevention (CDC) and the Office of Personnel Management (OPM)

Background on Phases 1 - 4:

Phase 4: On March 26, 2020, the BOP implemented revised preventative measures for all institutions The agency updated its quarantine and isolation procedures to require all newly admitted inmates to BOP, whether in a sustained community transition area or not, be assessed using a screening tool and temperature check This includes all new intakes, detainees, commitments, writ returns from judicial proceedings, and parole violators, regardless of their method of arrival Asymptomatic inmates are placed in quarantine for a minimum of 14 days or until cleared by medical staff Symptomatic inmates are placed in isolation until they test negative for COVID-19 or are cleared by medical staff as meeting CDC criteria for release from isolation

These are the latest measures that follow the first three phases of the Bureau's action plan, which may be found here: www bop gov/resources/news/pdfs/20200324_bop_press_release_covid19_update pdf

The Bureau will continue to provide daily updates and information on actions related to COVID-19 at www bop gov/coronavirus/

CDC Guidance on Management of COVID-19 in Correctional and Detention Facilities

Liesl Hagan, MPH

Epidemiologist

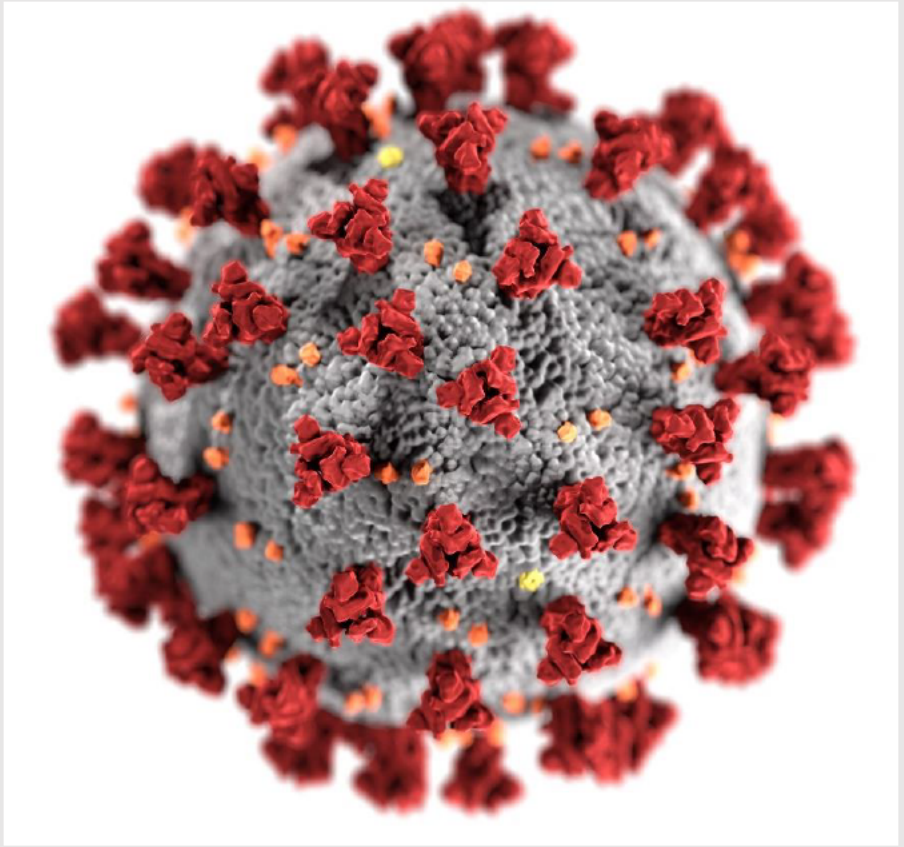
Community Interventions Task Force - Correctional Health

COVID-19 Response

Centers for Disease Control and Prevention

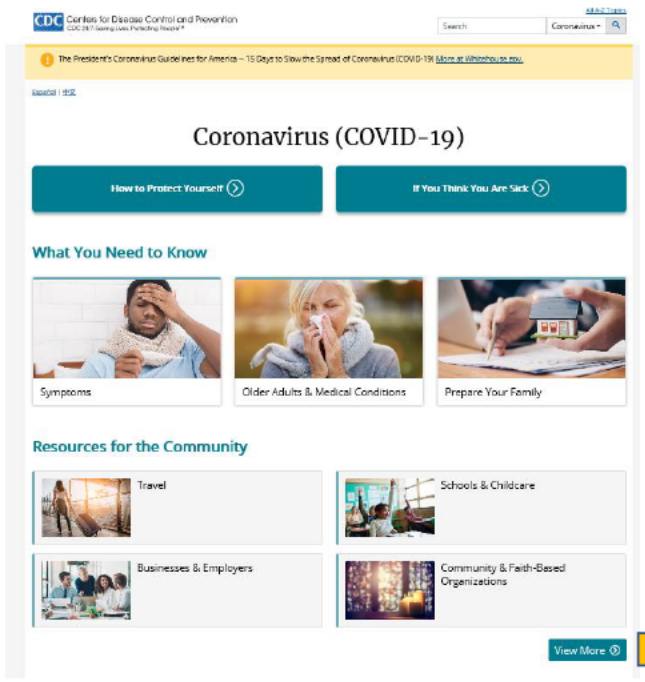
This interim guidance is based on what is currently known about the transmission and severity of coronavirus disease 2019 (COVID-19) as of March 30, 2020.

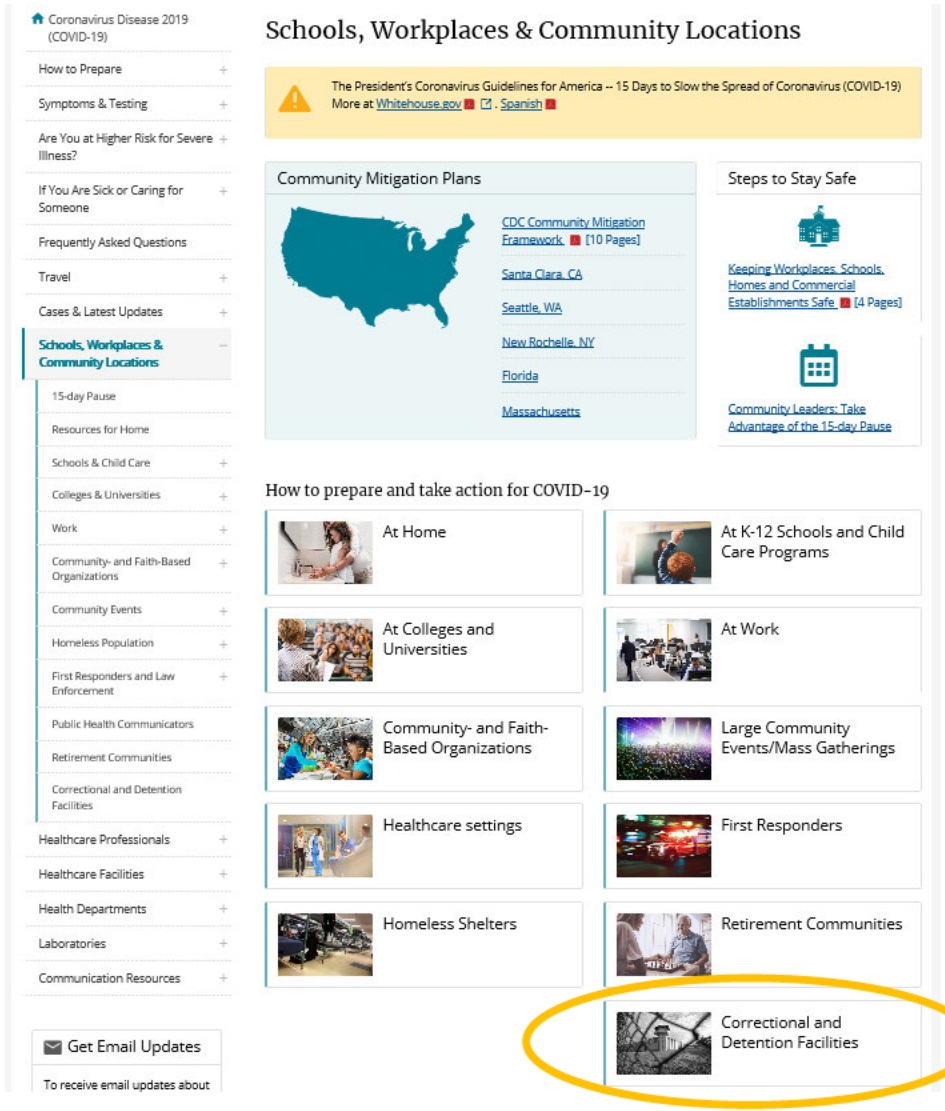
The US Centers for Disease Control and Prevention (CDC) will update this guidance as needed and as additional information becomes available. Please check the CDC website periodically for updated interim guidance.



cdc.gov/coronavirus

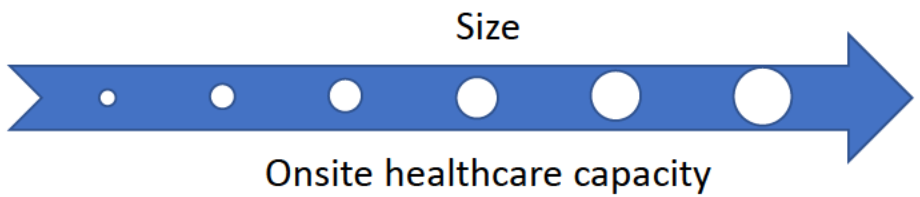
Finding the CDC guidance for corrections





https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html

What types of facilities does the guidance cover?



Navigating the CDC Guidance Document

1

PREPARE

Communications

Personnel Practices

Operations

Supplies

2

PREVENT

Hygiene

Cleaning

Screening for Symptoms

Social Distancing

3

MANAGE

Medical Isolation

Quarantine

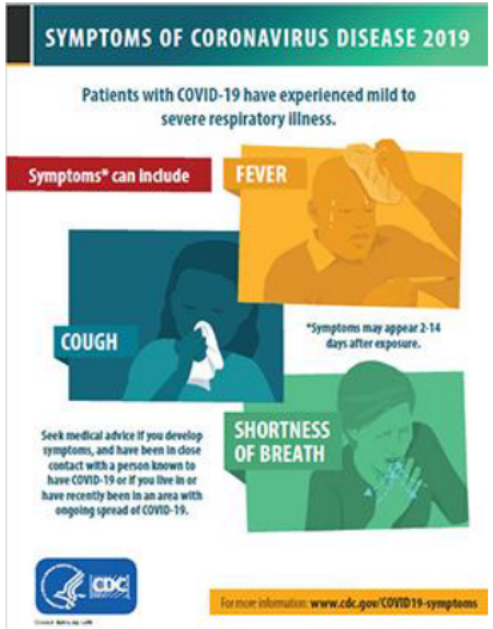
Infection Control

Clinical Care

Make sure to look at recommendations from all phases, regardless of whether you have cases

PREPARE

- **COMMUNICATE** with local public health
- **IDENTIFY** medical isolation and quarantine spaces ahead of time
- **PLAN** for staff absences and encourage sick employees to stay home
- **POST** information around the facility on COVID-19 symptoms and hygiene
- **CHECK** supply stocks (cleaning supplies, hand washing supplies, medical supplies, PPE)



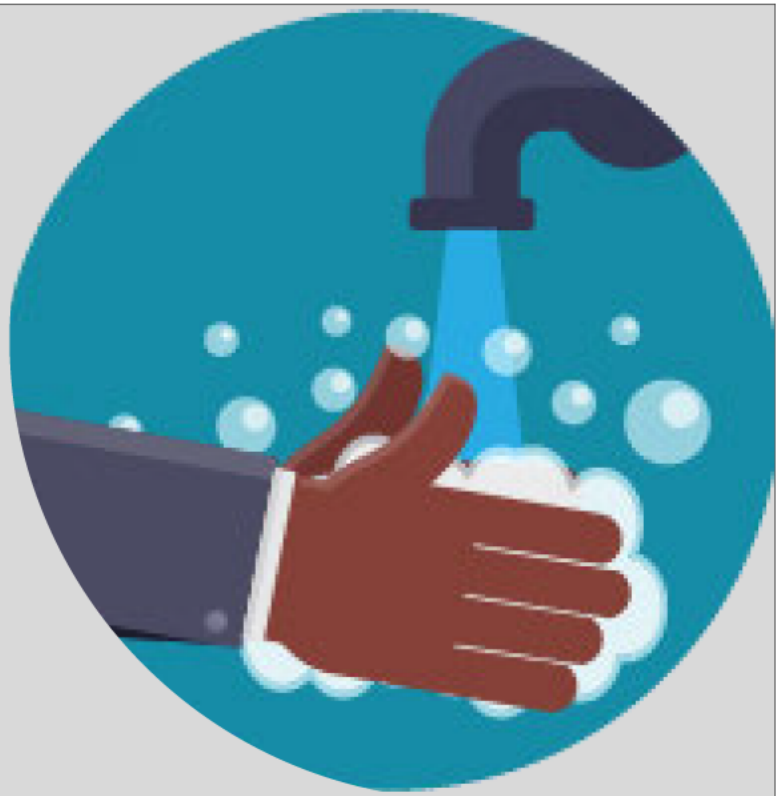
Communications Resources

https://www.cdc.gov/coronavirus/2019-ncov/communication/factsheets.html

A quick note on…SOAP

Make sure it is:

- Free
- Accessible
- Restocked continually
- Not irritating to skin



Alcohol-based hand sanitizer (at least 60% alcohol) is a good alternative when soap & water aren't available – consider loosening restrictions where feasible

PREVENT

- **RAMP UP** cleaning schedule & hand hygiene reminders
- **LIMIT** transfers between facilities
- **SCREEN** everyone coming in for symptoms (new intakes, staff, visitors)
- **IMPLEMENT** social distancing
- **MAKE SURE** everyone knows what to do if they have symptoms
- **ENCOURAGE** non-contact visits or consider suspending visitation

Screening

- **New intakes** – AT SALLYPORT
- **Incarcerated people leaving the facility**
- **Staff** – daily on entry
- **Visitors**

1. *Today or in the past 24 hours, have you had any of the following symptoms?*
   - *Fever, felt feverish, or had chills?*
   - *Cough?*
   - *Difficulty breathing?*

2. *In the past 14 days, have you had contact with a person known to be infected with coronavirus (COVID-19)?*

3. *Take the person's temperature*

Social Distancing

- Ideally 6 feet between people (sick or not)
- Decrease frequency of contact

Reduces risk of spreading disease

Social Distancing Examples for Corrections

NOT one-size-fits-all…each facility will need to choose what works for them

Common areas

- Enforce increased space between people in
  - holding cells
  - lines
  - waiting areas such as intake (e.g., remove every other chair in a waiting area)

Recreation

- Choose spaces where people can spread out
- Stagger time in recreation spaces
- Assign each housing unit a dedicated recreation space to avoid mixing and cross-contamination

Meals

- Stagger meals
- Rearrange seating in the dining hall (e.g., remove every other chair and use only one side of the table)
- Provide meals inside housing units or cells

Group activities

- Limit their size
- Increase space between people
- Suspend group programs where people will be in closer contact than in their housing environment
- Choose outdoor areas or other areas where people can spread out

Housing

- Reassign bunks to provide more space between people
- Sleep head to foot
- Minimize mixing of people from different housing areas

Medical

- Designate a room near each housing unit to evaluate people with COVID-19 symptoms
- Stagger sick call
- Designate a room near the intake area to evaluate new entrants who are flagged by the intake screening process

COMMUNICATE the reasons for social distancing

MANAGE

- **SUSPEND** all non-medical transfers
- **INTEGRATE** screening into release planning
- **COORDINATE** with public health
- **MASK & MEDICALLY ISOLATE** symptomatic people
- **IDENTIFY & QUARANTINE** close contacts
- **WEAR** recommended PPE
- **PROVIDE** clinical care or transfer for care
- **COMMUNICATE** clearly & often

MEDICAL ISOLATION

Who: Symptomatic people

What: MASK & separate from others

When: Immediately once symptoms appear

Where: Ideally, an individual cell

Why: Prevent exposing others
Evaluate, test if needed
Give care

How long: It's complicated
(More on next slide)

QUARANTINE

Who: Close contacts of a known or suspected case (staff or incarcerated)

What: Separate from others
Monitor for symptoms

When: Once identified as a close contact

Where: Ideally, an individual cell
(if incarcerated)
At home (if staff)

Why: Prevent exposing others if infected

How long: 14 days

Medical Isolation

Isolate anyone with symptoms of COVID-19

- MASK for source control
- Separate from others (individually if possible) & restrict movement
- Provide with tissues, trash can, and hand hygiene supplies
- Notify public health
- Clean & disinfect thoroughly
- Evaluate and test, if indicated
- Give care (or transfer for care)

Options for Medical Isolation

when multiple people need to be isolated due to COVID-19

IDEAL: SEPARATELY

- Single cells with solid walls & solid door
- Single cells with solid walls

NEXT BEST: AS A COHORT – *use social distancing*

- Large, well-ventilated cell with solid walls & solid door
- Large, well-ventilated cell with solid walls
- Single, barred cells (ideally with empty cell between)
- Multi-person, barred cells (ideally with empty cell between)

LAST RESORT: TRANSFER

- Transfer to a facility with isolation space

  (LAST RESORT due to possibility of introducing COVID-19 to another facility)

CAUTIONS for Cohorting COVID-19 Cases

DO NOT COHORT CONFIRMED CASES WITH SUSPECTED CASES

DO NOT COHORT CASES WITH UNDIAGNOSED RESPIRATORY INFECTIONS

PRIORITIZE SINGLE CELLS FOR PEOPLE AT HIGHER RISK OF SEVERE ILLNESS FROM COVID-19

- Older adults
- People with serious underlying medical conditions

USE SOCIAL DISTANCING AS MUCH AS POSSIBLE

When Does Medical Isolation End?

Test-based strategy

- Fever-free for ≥72 hours (without fever reducing medications) **AND**
- Respiratory symptoms have improved **AND**
- Tested negative in ≥2 consecutive respiratory specimens collected ≥24 hours apart

Symptom-based strategy

- Fever-free for ≥72 hours (without fever reducing medications) **AND**
- Respiratory symptoms have improved **AND**
- At least 7 days have passed since the first symptoms appeared

If the person had a positive test but never had symptoms

- At least 7 days have passed since the first positive COVID-19 test **AND**
- The person has had no subsequent illness

Quarantine

A close contact is anyone who:

- Has been within 6 feet of a confirmed/suspected case for a prolonged period of time

OR

- Has had contact with infectious secretions from a confirmed/suspected case (e.g., coughed on)

- Identify close contacts
- Mask as source control, if PPE stocks allow
- Separate from others (ideally individually) & restrict movement
- Monitor symptoms 2x per day
- If symptoms develop, immediately mask and medically isolate
- If cohorting and another case develops, 14-day clock restarts
- Return to previous housing and lift movement restrictions after 14 days if no symptoms develop

Options for Quarantine

when multiple close contacts of a COVID-19 case need to be quarantined

IDEAL: SEPARATELY

- Single cells with solid walls & solid door
- Single cells with solid walls

NEXT BEST: AS A COHORT – *use social distancing*

- Large, well-ventilated cell with solid walls & solid door
- Large, well-ventilated cell with solid walls
- Single, barred cells (ideally with empty cell between)
- Multi-person, barred cells (ideally with empty cell between)
- If a whole housing unit has been exposed: quarantine in place, with no movement outside the unit

LAST RESORT: TRANSFER

- Transfer to a facility with quarantine space

(LAST RESORT due to possibility of introducing COVID-19 to another facility)

CAUTIONS for Cohorting Close Contacts of COVID-19 Cases

MONITOR SYMPTOMS CLOSELY, AND IMMEDIATELY PLACE SYMPTOMATIC PEOPLE UNDER MEDICAL ISOLATION TO PREVENT FURTHER SPREAD

(14-DAY CLOCK RESTARTS)

PRIORITIZE SINGLE CELLS FOR PEOPLE AT HIGHER RISK OF SEVERE ILLNESS FROM COVID-19

- Older adults
- People with serious underlying medical conditions

DO NOT ADD PEOPLE TO AN EXISTING QUARANTINE COHORT

DO NOT MIX PEOPLE QUARANTINED DUE TO EXPOSURE WITH PEOPLE UNDER ROUTINE INTAKE QUARANTINE

Clinical Care for Patients with COVID-19

- **Refer to full CDC guidance at https://www.cdc.gov/coronavirus/2019-nCoV/index.html:**
  - Evaluating and Testing Persons for Coronavirus Disease 2019 (COVID-19)
  - CDC Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease (COVID-19)
- **Evaluate people for COVID-19 at the first sign of symptoms**
  - Include assessment of high risk status
  - Test for other causes of respiratory illness (e.g., influenza)
- **Have a plan in place to safely transport cases to a local hospital if they need care beyond what the facility can provide**

Infection Control & PPE

- **Refer to full CDC guidance at https://www.cdc.gov/coronavirus/2019-nCoV/index.html:**
  - CDC Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings
  - NOTE: language is not specific for correctional settings – implement as fully as able, may need to adapt
- **Assess PPE needs based on the type of contact a person has with a confirmed/suspected COVID-19 case** (see full guidance document and accompanying PPE table – details on next 2 slides)
- **Minimize contact with a symptomatic person until that person is wearing a mask** (6 feet if possible)
- **Clean duty belt, gear, clothing that comes into contact with a symptomatic person**
- **Wash hands thoroughly after any contact**

Infection Control & PPE

- **Nationwide shortages are expected for all PPE categories:**

- **Refer to CDC's guidance on optimizing PPE supplies:** https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html

  Some strategies include:

  - **N95 respirators:** Face masks are an acceptable alternative to N95 respirators when supplies are limited. N95s should be prioritized for procedures expected to generate infectious aerosols.
  - **Face masks:** Extended use for multiple patients; use beyond shelf life; reuse; prioritize for splashes/sprays; increase ventilation; homemade masks
  - **Eye protection:** Choose reusable options if available; use beyond shelf life; extended use for multiple patients; clean disposable units; prioritize for splashes/sprays
  - **Gowns**: Cloth/reusable options; use beyond shelf life; use gowns meeting international standards; prioritize for splashes/sprays/high-contact; other garments

Recommended PPE

PPE recommended for staff and incarcerated people depends on the level of contact they have with COVID-19 cases and/or contaminated materials

2nd to last page of guidance document

NOTE: Change to table forthcoming – staff performing temperature checks do NOT need to wear gowns/coveralls.

Table 1. Recommended Personal Protective Equipment (PPE) for Incarcerated/Detained Persons and Staff in a Correctional Facility during the COVID-19 Response

Classification of Individual Wearing PPE	N95 respirator	Face mask	Eye Protection	Gloves	Gown/ Coveralls
Incarcerated/Detained Persons					
Asymptomatic incarcerated/detained persons (under quarantine as close contacts of a COVID-19 case*)	Apply face masks for source control as feasible based on local supply, especially if housed as a cohort				
Incarcerated/detained persons who are confirmed or suspected COVID-19 cases, or showing symptoms of COVID-19	–	✓	–	–	–
Incarcerated/detained persons in a work placement handling laundry or used food service items from a COVID-19 case or case contact	–	–	–	✓	✓
Incarcerated/detained persons in a work placement cleaning areas where a COVID-19 case has spent time	Additional PPE may be needed based on the product label. See CDC guidelines for more details.			✓	✓
Staff					
Staff having direct contact with asymptomatic incarcerated/detained persons under quarantine as close contacts of a COVID-19 case* (but not performing temperature checks or providing medical care)	–	Face mask, eye protection, and gloves as local supply and scope of duties allow.			–
Staff performing temperature checks on any group of people (staff, visitors, or incarcerated/detained persons), or providing medical care to asymptomatic quarantined persons	–	✓	✓	✓	✖
Staff having direct contact with (including transport) or offering medical care to confirmed or suspected COVID-19 cases (see CDC infection control guidelines)	✓**		✓	✓	✓
Staff present during a procedure on a confirmed or suspected COVID-19 case that may generate respiratory aerosols (see CDC infection control guidelines)	✓	–	✓	✓	✓
Staff handling laundry or used food service items from a COVID-19 case or case contact	–	–	–	✓	✓
Staff cleaning an area where a COVID-19 case has spent time	Additional PPE may be needed based on the product label. See CDC guidelines for more details.			✓	✓

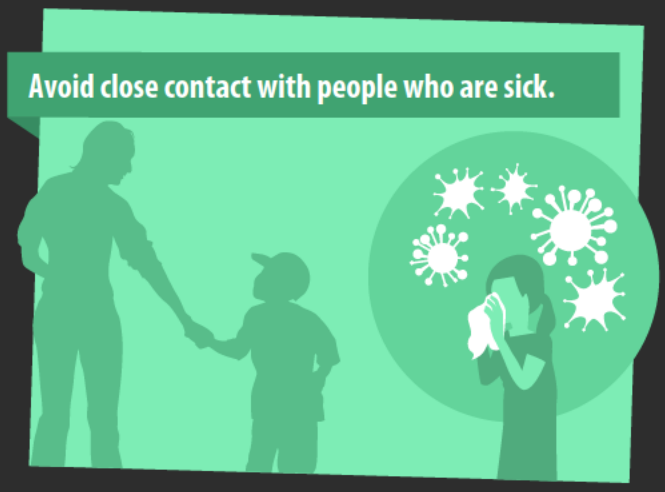
* If a facility chooses to routinely quarantine all new intakes (without symptoms or known exposure to a COVID-19 case) before integrating into the facility's general population, face masks are not necessary.
**A NIOSH-approved N95 is preferred. However, based on local and regional situational analysis of PPE supplies, face masks can be used as an alternative when the supply chain of respirators cannot meet the demand. During this time, available respirators should be prioritized for procedures that are likely to generate respiratory aerosols, which would pose the highest exposure risk to staff.

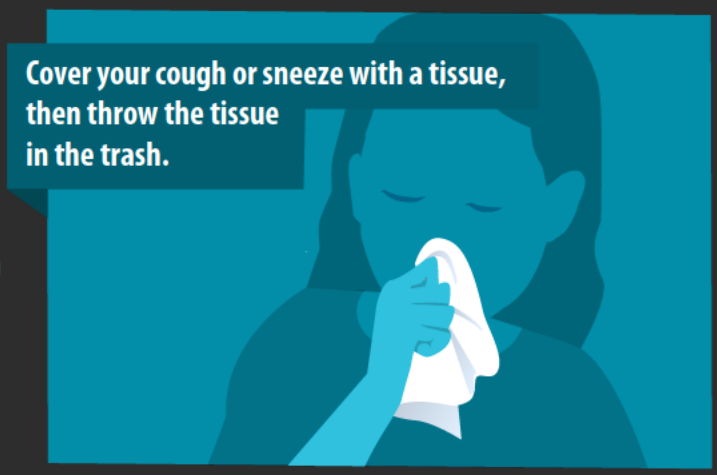
Q & A

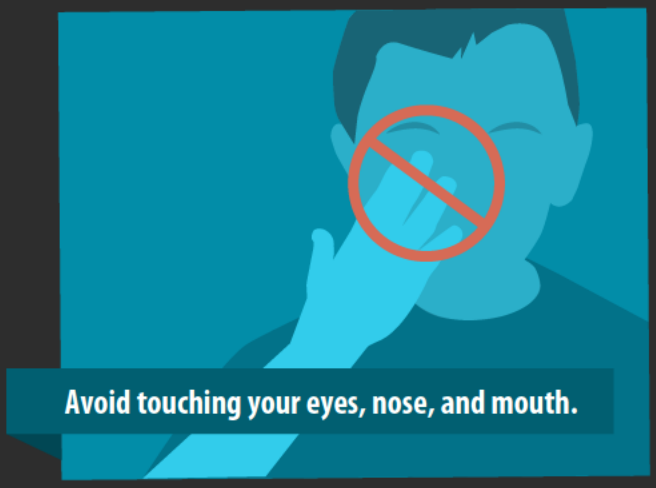
COVID 19 CORONAVIRUS DISEASE

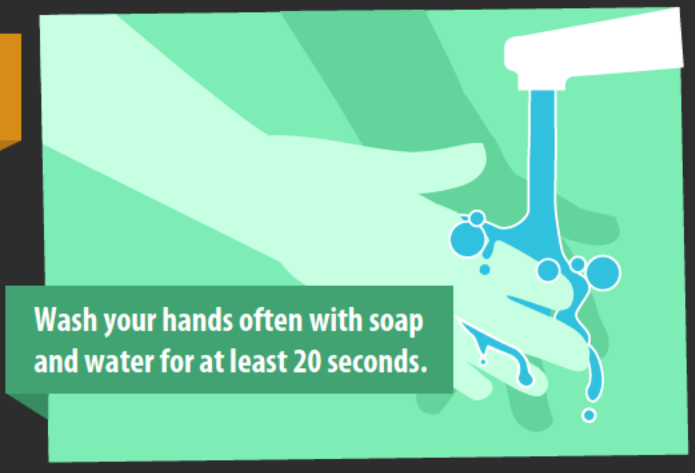
STOP THE SPREAD OF GERMS

Help prevent the spread of respiratory diseases like COVID-19.









HHS CDC

For more information: www.cdc.gov/COVID19

CS314915-A

CORONAVIRUS DISEASE 2019 (COVID-19) INMATE SCREENING TOOL

1. Assess the Risk Of Exposure	
☐ Yes ☐ No	Traveled from, or through, any of the locations identified by the CDC as increasing epidemiologic risk within the last 14 days? Link to CDC Criteria
☐ Yes ☐ No	Had close contact with anyone diagnosed with the COVID-19 illness within the last 14 days?

If the answer to ALL the above risk of exposure questions is NO, then STOP here and proceed with normal intake.
If the answer to ANY of the above risk of exposure questions is YES, then immediately assess symptoms.

2. Assess Symptoms		Date of Onset:
☐ Yes ☐ No	**Fever** (*Fever may not be present in some patients, such as elderly, immunosuppressed, or taking certain medications. Fever may be subjective or objective).*	
☐ Yes ☐ No	**Cough**	
☐ Yes ☐ No	**Shortness of Breath (SOB)**	

3. Implement Infection Prevention Control Measures *if YES to the above questions in (2).*

3a. The Symptomatic Patient

If the patient has any symptoms, implement Standard, Contact, and Airborne Precautions with Eye Protection

- ☐ Report case promptly to facility leadership, infection prevention and control (IPC), public health and Regional and Central Office QIIPC Consultants.
- ☐ Place a surgical mask on the patient and minimize proximity to staff and inmates
- ☐ All staff escorting, evaluating, or in close contact (6 ft.) with the patient should perform hand hygiene, put on gloves, gown, fit-tested respirator (N-95), goggles or face shield and gloves before room entry or inmate contact. Inmate will wear a surgical mask. Doffing: gloves, gown, exit room, doff face shield then N-95 and wash hands.
- ☐ Escort patient to a *certified* Airborne Infection Isolation (AII) room.
- ☐ If no AII room is available, isolate in room with door closed and *preferably* air is exhausted outside.
- ☐ Prepare for transport to a designated referral healthcare facility in coordination with the local public health authority (do not call for transport service without prior notification and escort in place to move inmate).
- ☐ Minimize and keep a log of all persons interacting with (6ft.) or caring for, the inmate.
- ☐ Once the AII room is empty for two hours, it can be cleaned and disinfected with an EPA registered disinfectant (Emerging viral pathogens claim), by a person in proper PPE.
- ☐ Waste disposal: Double bag trash as hazardous waste. Linens: Double bag in linen hazard bag for washing in central laundry

3b. The Asymptomatic Patient

If the patient has no symptoms house in a single cell, and implement Standard, Contact and Droplet Precautions with Eye Protection

- ☐ Report case to facility leadership, QIICP, public health and Regional and Central Office QIIPC Consultants.
- ☐ House patient in a single cell. The preferred location is within Health Services. If unable to house patient in a single cell contact Regional and Central Office Infection Prevention and Control Consultants.
- ☐ Limit # of persons interacting with inmate. Utilize social distancing (6 ft.).
- ☐ Document a daily symptom assessment and temperature (Inmate can self-monitor with disposable thermometer or use non-contact thermometer. Utilize disposable food trays. Have inmate clean and disinfect room daily with disposable towels, if possible. Trash will be double bagged out of room.
- ☐ Staff entering room will perform hand hygiene, wear a gown, surgical mask, goggles or face shield and gloves. Inmate will wear a surgical mask. Remove PPE, except face shield and mask at exit. Outside room, remove mask and wash hands.
- ☐ Continue modified housing and observation procedures until 14 days after the last possible exposure date.
- ☐ If at any time the patient becomes symptomatic, implement the steps in 3a – The Symptomatic Patient.

Inmate Name (Last, First): _____ **Registration #** _____
Institution: _____
Provider Name/Signature: _____ **Date:** _____

February 2020, Version 2.0

Coronavirus
COVID-19

PRIORITIES FOR TESTING PATIENTS WITH SUSPECTED COVID-19 INFECTION

COVID-19 Symptoms: Fever, Cough, and Shortness of Breath

PRIORITY 1

Ensures optimal care options for all hospitalized patients, lessen the risk of healthcare-associated infections, and maintain the integrity of the U.S. healthcare system

- Hospitalized patients
- Healthcare facility workers with symptoms

1

2

PRIORITY 2

Ensures those at highest risk of complication of infection are rapidly identified and appropriately triaged

- Patients in long-term care facilities with symptoms
- Patients 65 years of age and older with symptoms
- Patients with underlying conditions with symptoms
- First responders with symptoms

PRIORITY 3

As resources allow, test individuals in the surrounding community of rapidly increasing hospital cases to decrease community spread, and ensure health of essential workers

- Critical infrastructure workers with symptoms
- Individuals who do not meet any of the above categories with symptoms
- Healthcare facility workers and first responders
- Individuals with mild symptoms in communities experiencing high numbers of COVID-19 hospitalizations

3

NON-PRIORITY

NON-PRIORITY

- Individuals without symptoms

For more information visit: coronavirus.gov

Federal Bureau of Prisons
Health Services Division

Pandemic Influenza Plan

Module 2:
Antiviral Medications and Vaccines

October 2012

BOP Pandemic Influenza Response Stages

The BOP *Pandemic Influenza Plan* is divided into the three stages that are used for standard BOP contingency plans; in this plan, the three stages are designed to correlate with the Federal Government Response Stages for pandemic influenza.

The BOP Pandemic Influenza Response Stages are as follows:

- **PREPARATION** (Federal Response Stages 0–1). Most of the detail in this plan involves the preparation phase.
- **RESPONSE** (Federal Response Stages 2–5). This phase, which begins when it is announced that there are confirmed human outbreaks overseas, involves both making last-minute preparations and actually responding to pandemic flu.
- **RECOVERY** (Federal Response Stage 6). This phase involves recovering from the pandemic, evaluating actions taken during the pandemic, and preparing for more flu. Based on what we know from previous pandemics, subsequent waves of flu are likely to follow once the pandemic flu has subsided.

Federal Government Response Stages*		BOP Influenza Plan	
		Federal Stages	BOP Stage
0	New domestic animal outbreak in at-risk country	**0-1**	**PREPARATION**
1	Suspected human outbreak overseas		
2	Confirmed human outbreak overseas	**2-5**	**RESPONSE**
3	Widespread human outbreaks in multiple locations overseas		
4	First human case in North America		
5	Spread throughout United States		
6	Recovery & preparation for subsequent waves	**6**	**RECOVERY**

**The Federal Government Response Stages should not be confused with the World Health Organization phases of pandemic influenza.*

Table of Contents

Overview

Module 2 covers the following information:

1. ***Antiviral medications****—stockpiling, distribution, and use*
2. ***Pandemic vaccine****—preparing for mass vaccination*
3. ***Seasonal flu vaccination****—increasing annual vaccination among staff and inmates*
4. ***Pneumococcal vaccination****—increasing vaccination among eligible staff and inmates*

1. Antiviral Medications

Antiviral medications may help decrease the illness and death due to influenza. Should transmission of pandemic influenza become widespread, the most important goals of using antiviral medication are: (1) to prevent serious morbidity and death; and (2) to preserve the delivery of health care and other essential services, through early treatment and limited prophylaxis.

Antivirals can be used in three ways:

- **Treatment:** To treat flu cases (ideally should be started within 48 hours of symptom-onset).
- **Post-exposure prophylaxis:** To prevent the flu after exposure to someone sick with flu.
- **Prophylaxis:** To prevent the flu during an ongoing outbreak.

Early treatment is a more efficient use of antiviral medication than widespread prophylaxis. Two brands of antivirals are effective for treating influenza: oseltamivir (Tamiflu®) and zanamivir (Relenza®). BOP is stockpiling both drugs.

Antiviral Treatment Recommendations

Treatment with oseltamivir or zanamivir is recommended for all persons with suspected or confirmed influenza requiring hospitalization. Treatment may be recommended for persons with suspected or confirmed influenza who are at higher risk for complications. In the event of pandemic influenza, the BOP Medical Director will issue specific guidance regarding high-risk groups to treat with antiviral medication.

The following are general recommendations regarding antiviral treatment. Prescribing information for oseltamivir and zanamivir are provided in *Attachment 2.1*.

- Oseltamivir is the generally recommended antiviral recommended for treatment during pregnancy.
- Zanamivir is contraindicated for inmates with airway disease.
- Treatment should not wait for laboratory confirmation of influenza because laboratory testing can delay treatment and because a negative rapid test for influenza does not rule out influenza.
- Treatment should be initiated as early as possible because studies show that treatment initiated early (i.e., within 48 hours of illness onset) is more likely to provide benefit.
- Clinical judgment is an important factor in antiviral treatment decisions for all patients presenting for medical care who have illnesses consistent with influenza.
- Persons who are not at higher risk for complications or do not have severe influenza requiring hospitalization generally *do not* require antiviral medications for treatment or prophylaxis. However, any suspected influenza patient presenting with warning signs and symptoms for lower respiratory tract illness (e.g., shortness of breath, rapid breathing, unexplained oxygen desaturation) should promptly receive empiric antiviral therapy.
- Clinicians should do the following to reduce delays in initiating antiviral treatment, including:

- Inform inmates at higher risk for influenza complications about the signs and symptoms of influenza and the need for early treatment after the onset of influenza symptoms (i.e., fever, respiratory symptoms).
- Start empiric treatment of patients at higher risk for influenza complications as soon as possible. See prescribing information for additional information.

Antiviral Post-Exposure Prophylaxis Recommendations

Antiviral post-exposure prophylaxis involves providing medication to prevent development of influenza. Because use of antiviral medications for prophylaxis may contribute to the development of antiviral resistant influenza strains, antiviral prophylaxis will be provided within the BOP only under a limited number of circumstances as discussed in *Table 1* below.

Table 1. Influenza Antiviral Prophylaxis within the BOP

- **Inmates who are close contacts to persons with ILI who have medical conditions which place them at high risk for influenza complications** may be candidates for antiviral prophylaxis, based upon guidance from the Medical Director. Pregnant inmates are the highest priority.
- **In the event of significant health care shortages, health care workers (HCWs) who are close contacts to ILI cases may be offered antiviral prophylaxis.** The use of antiviral prophylaxis under this circumstance requires approval of the BOP Medical Director. Unless they take antiviral prophylaxis, exposed HCWs should not be assigned to care for inmates who are at high risk for influenza complications for the 4 days following potential exposure, i.e., 24 hours after fever resolves in the close contact(s) with ILI.
- **In the event of significant correctional staff shortages, BOP institutions can consider general antiviral prophylaxis of staff in order to maintain adequate staffing.** The use of antiviral prophylaxis under this circumstance requires the approval of the BOP Medical Director.

- For the purposes of assessing possible exposure, the infectious period—the time period when an exposure may have occurred—is one day before ILI symptoms occur until 24 hours after fever ends.
- Two drugs can be used for prophylaxis: oseltamivir and zanamivir. Pregnant women who are close contacts to a person with ILI are high priority for prophylaxis. Oseltamivir is generally recommended for pregnant women.
- Antiviral agents should not be used for post-exposure prophylaxis in healthy inmates.
- Antiviral prophylaxis generally is not recommended if more than 48 hours have elapsed since the last contact with an infectious person. Prophylaxis is not indicated when contact occurred before or after, but not during, the ill person's *infectious period* (as defined in the first bullet above). An emphasis on early treatment is an alternative to prophylaxis after a suspected exposure.

2. Pandemic Vaccine

The BOP will utilize CDC-defined priorities for prioritizing administration of a pandemic vaccine once it is developed and released for distribution. In the event of a pandemic, the BOP Medical Director will issue guidance regarding how the vaccine will be obtained and the priority groups for vaccination. Local institutions should have plans in place for mass vaccination.

Guidance on planning mass vaccination clinics is available at:
http:www.cdc.gov/flu/professionals/vaccination/vax_clinic.htm.

3. Seasonal Flu Vaccine

Increasing the number of inmates and employees who are vaccinated for seasonal flu will decrease the occurrence of seasonal flu during a pandemic. It will also help the institution be prepared logistically for mass vaccination if a pandemic vaccine is available.

4. Pneumococcal Vaccine

It is generally recommended that pneumococcal vaccine be administered to individuals who are at high risk for complications from bacterial pneumonia (see *Table 2* below). Preparation for pandemic flu includes improving pneumococcal vaccine coverage, thereby reducing the number of high risk individuals who develop bacterial pneumonia after becoming sick with pandemic flu. Inmates with risk factors should be identified and vaccinated. Employees should be educated to obtain pneumococcal vaccine from their personal health care provider if they have risk factors.

Table 2. Risk Factors for Complications from Bacterial Pneumonia

• chronic pulmonary disease (excluding asthma) • cardiovascular diseases • diabetes mellitus • chronic liver diseases • chronic renal failure or nephrotic syndrome • functional or anatomic asplenia (e.g., sickle cell disease or splenectomy)	• immunosuppressive conditions (e.g., congenital immunodeficiency, HIV infection, leukemia, lymphoma, multiple myeloma, Hodgkin's disease, generalized malignancy, or organ transplantation) • chemotherapy with alkylating agents, antimetabolites, or long-term systemic corticosteroids • cochlear implants • cerebrospinal fluid leaks • chronic alcoholism

Action Steps by Pandemic Stage

Preparation (Federal Response Stages 0–1)
(See *Standard Operating Procedures*, which are provided for the Preparation stage only.)

1. Identify a health care staff person to be responsible for the planning for antiviral medication and vaccines.
2. Increase *seasonal flu* vaccination rates for employees and inmates.
3. Increase *pneumococcal* vaccination coverage rates for employees and inmates who have risk factors for pneumococcal pneumonia. (Employees must obtain via personal health care provider.)
4. Coordinate with local health department partners to ensure inclusion in the Strategic National Stockpile for *pandemic vaccine*.
5. Stockpile medications for community acquired pneumonia per recommendations of the BOP Medical Director.
6. Develop local plan for obtaining antivirals stockpiled in the region (coordinating with the Regional Office, in accordance with the regional distribution plan).
7. Educate employees and inmates regarding the need and rationale for assigning priorities for receiving *antiviral medication* and *pandemic vaccine*.
8. Develop local procedures for providing *antiviral medication* and *pandemic vaccine* to employees and inmates in accordance with federal law as well as BOP policies and procedures.

Response (Federal Response Stages 2–5)

Begin when there are confirmed human outbreaks of pandemic flu anywhere in the world:

1. Provide seasonal flu vaccine to high priority inmates and staff.
2. Review the priority groups for antiviral medication and criteria for prophylaxis as defined by the Medical Director.
3. Educate staff regarding the need for and rationale for priority groups.
4. All facilities should maintain a recommended stock of antiviral medication per direction of the BOP Medical Director. Facilities that house women should maintain an adequate stock of oseltamivir to provide treatment and prophylaxis to all pregnant inmates.
5. Review plans for accessing the Regional stockpile of antiviral medications (if demand exceeds local supply).
6. Finalize plans for mass vaccination, including arrangements for storage of vaccine.

(continued on next page)

Begin after a suspected pandemic influenza case is diagnosed in the facility:

7. Dispense antiviral medications and administer vaccinations according to priority groups.

8. Monitor for antiviral adverse events and report them using MEDWATCH Form FDA 3500.

9. Monitor adverse events from pandemic influenza vaccine and report them using the Vaccine Adverse Event Reporting System Form (VAERS-1).

10. Monitor efficacy and resistance patterns of antivirals.

11. Monitor efficacy of the vaccine.

12. Monitor antiviral/vaccine supplies, distribution, and use.

Recovery (Federal Response Stage 6)

Previous flu pandemics have been associated with subsequent "waves" of flu after an initial wave resolves. After an initial pandemic flu outbreak, subsequent outbreaks are likely. The recovery period will involve both recovering from the pandemic emergency, evaluating the BOP response to it, and preparing for subsequent waves of pandemic flu.

1. Evaluate efficacy and resistance of antivirals and pandemic influenza vaccine.

2. Evaluate adverse reactions of antiviral medications and pandemic influenza vaccine.

3. Assess whether the supply of antiviral medication and pandemic vaccine, as well as the supplies necessary for their delivery, were adequate.

4. Assess coordination with state and local health partners, as well as access to the Strategic National Stockpile.

5. Evaluate the effectiveness of the system for dispensing antivirals and administering vaccine.

Module 2: Standard Operating Procedures for Preparation Stage
(Federal Response Stages 0–1)

During the Preparation stage, adapt this Standard Operating Procedure template to the unique circumstances of your facility. A modifiable Word version is posted on: www.bop.gov/news/medresources.jsp.

1. Identify staff persons responsible for planning for the planning for antiviral medication and vaccines.

In this facility, the following individual is assigned responsibility:

2. Increase seasonal flu vaccination rates for employees and inmates.

Annually review influenza vaccination rates. Set goals for improvement for the next season.

a. Outline plan in this facility for improving employee vaccination rates.

b. Outline plan in this facility for improving inmate vaccination rates.

3. Increase *pneumococcal* vaccination coverage rates for employees and inmates who have risk factors for pneumococcal pneumonia.

a. Employees: Develop strategies for promoting pneumococcal vaccine for employees with risk factors. It will not be possible to track employee pneumococcal vaccinations since they are provided by their private practitioners.

In this facility, the following plan will be utilized to promote pneumococcal vaccine for employees:

b. Inmates: Develop a system for identifying inmates with risk factors for pneumococcal pneumonia.

In this facility the following plan will be followed to improve pneumococcal vaccine coverage for inmates:

4. Coordinate with local health department partners to ensure inclusion in the Strategic National Stockpile for *pandemic vaccine*.

Contact local health department regarding Strategic National Stockpile. Advocate that your facility be part of the plan. Document discussions and attach to the plan.

5. Stockpile medications for community acquired pneumonia per BOP Medical Director.

Determine quantity and type of antibiotics to be stockpiled and plans for rotating stock.

6. Develop local plan for obtaining antivirals stockpiled in the region (coordinating with the Regional Office, in accordance with the regional distribution plan).
a. In the event of pandemic flu, plans for obtaining stockpiled antivirals are:
b. Identify location for storing antivirals in this facility. (For security reasons, do not record location in this document.)
c. Plan for securing antivirals in this facility. The plan is:
7. Educate employees and inmates regarding the need and rationale for assigning priorities for receiving *antiviral medication* and *pandemic vaccine*.
Indicate how and when education about priorities for antiviral medication and pandemic vaccine will be incorporated into general training about pandemic flu:
8. Develop local procedures for providing *antiviral medication* and *pandemic vaccine* to employees and inmates.
Detail separate procedures for providing antiviral medication and administering pandemic vaccine (including identifying needed supplies and plans for obtaining them):

Attachments

Attachment 2.1: Prescribing Information for Zanamivir and Oseltamivir

Attachment 2.2: Antiviral Medication – Medical Evaluation, Consent, and Prescribing

Attachment 2.3: Guidance for Acquisition, Storage, and Use of Antiviral Medication Procurement

Attachment 2.4: Quarterly Pandemic Influenza Medication Certification

Attachment 2.1. Prescribing Information for Zanamivir and Oseltamivir

Zanamivir (Relenza®)

How Supplied and Storage

Relenza (GlaxoSmithKline) **Powder**. Blister for inhalation. Four 5 mg blisters of powder on a ROTADISK® for oral inhalation via DISKHALER®. Packaged in carton containing 5 ROTADISKs (total of 10 doses) and 1 DISKHALER inhalation device.

Store DISKHALER and blister packs at 77°F (excursions permitted from 59° to 86°F). Do not puncture any blister until just before inhaling a dose.

Indications and Administration Dose

Uncomplicated acute illness caused by influenza A and B virus in adults and children 7 yr of age and older who have been symptomatic for no longer than 2 days; prophylaxis of influenza in adults and children 5 yr of age and older. For oral inhalation only (not nasal inhalation).

Influenza Treatment: *Adults and children 7 years of age and older:* Oral inhalation: Two 5 mg inhalations (10 mg total) twice per day for 5 days. Treatment generally should begin within 2 days of onset of influenza. Two doses should be taken on the first day of treatment whenever possible, provided there is at least 2 hours between doses. On subsequent days, doses should be about 12 hours apart at approximately the same time each day.

Influenza Post-Exposure Prophylaxis: *Adults and children 5 yr of age and older:* Oral inhalation: 2 inhalations (one 5 mg blister per inhalation) once daily for 10 days. Treatment should begin within 2 days of exposure.

Influenza Prophylaxis Community Outbreak: *Adults and adolescents:* Oral inhalation: 2 inhalations (one 5 mg blister per inhalation) once daily for 28 days.

Contraindications

Do not use in patients with history of allergic reactions to any ingredient of Relenza® including lactose (which contains milk proteins).

Warnings and Precautions

- ***Pregnancy:*** Category C.
- ***Lactation:*** Undetermined.
- ***Bronchospasm:*** Serious, sometimes fatal cases have occurred. *Not recommended in individuals with underlying airway disease* (including asthma and chronic obstructive pulmonary disease). Discontinue Relenza® if bronchospasm or decline in respiratory function develops.
- ***Hypersensitivity:*** Allergic-like reactions, including oropharyngeal edema, serious skin rashes, and anaphylaxis, have been reported in postmarketing experience, including in patients sensitive to lactose (milk proteins).
- ***High-risk patients:*** Safety and efficacy not demonstrated in patients with high-risk underlying medical conditions.
- ***Neuropsychiatric events:*** Delirium and abnormal behavior leading to injury have been reported in postmarketing experience.

Zanamivir (Relenza®) — continued

Adverse Reactions

The most common adverse events reported in >1.5% of patients treated with Relenza® and more commonly than in patients treated with placebo are:

- ***Treatment Studies:*** dizziness, sinusitis
- ***Prophylaxis Studies:*** fever and/or chills, arthralgia and articular rheumatism

Drug Interactions

Live attenuated influenza vaccine, intranasal:

- Do not administer until 48 hours following cessation of Relenza®.
- Do not administer Relenza® until 2 weeks following administration of the live attenuated vaccine, unless medically indicated.

Pharmacology and Pharmacokinetics

- Inhibition of influenza virus neuraminidase, affecting release of virus particles.
- ***Absorption:*** About 4% to 17% of orally inhaled dose is systemically absorbed. C max is 17 to 142 ng/mL, and T max is 1 to 2 hours following a 10 mg dose. The AUC is 111 to 1,364 ng$h/mL.
- ***Excretion:*** Renally excreted as unchanged drug in urine. Serum half-life is 2.5 to 5.1 h. Total Cl is 2.5 to 10.9 L/h. Unabsorbed drug is excreted in feces.

Oseltamivir (Tamiflu®)

How Supplied and Storage

- 30 mg capsules, blister pack of 10 capsules
- 45 mg capsules, blister pack of 10 capsules
- 75 mg capsules, blister pack of 10 capsules.
- Powder for oral suspension (12 mg/ml after reconstitution), 25 ml bottle.

Store at 77°F (with excursions allowed 59° to 86°) for both capsules and suspension.

Indications and Administration Dose

Influenza Treatment: For uncomplicated acute illness from influenza viruses type A and B, in patients greater than 12 months old who have been symptomatic for no more than 2 days.

- ***Adults and Adolescents ≥ 13 years old:*** 75 mg twice daily for 5 days. Begin treatment within 2 days of onset of symptoms.
- ***Renal Function Impairment*** *(creatinine clearance between 10–30 ml/min):* 75 mg once daily for 5 days.

Post-Exposure Prophylaxis: For adults and adolescents exposed to influenza type A and B in there are two situations in which prophylaxis can be used: (1) after a discrete exposure (one 10-day course); and (2) in the context of ongoing exposure.

- ***Adults and Adolescents > 13 years old:*** 75 mg once daily for at least 10 days. Therapy should start within 2 days of exposure. Safety and efficacy in a community outbreak setting have been demonstrated for up to 6 weeks in immunocompetent patients and up to 12 weeks in immunocompromised patients.
- ***Renal Function Impairment*** *(creatinine clearance between 10–30 ml/min):* 75 mg capsule every other day or 30 mg every day

Oseltamivir (Tamiflu®) — continued

Contraindications

- Hypersensitivity to any component.

Warnings and Precautions

- Should not affect the evaluation of individuals for annual influenza vaccination.
- ***Pregnancy Category C:*** Animal studies suggest that fetal risk is possible, but there is no evidence that Oseltamivir is harmful in humans. Benefits should outweigh risks.
- ***Lactation:*** Excretion through lactation was mild in animal studies, but it is not known whether Oseltamivir is excreted in human milk. Benefits should outweigh risks.
- Cases of anaphylaxis and serious skin reactions including toxic epidermal necrolysis, Stevens-Johnson Syndrome, and erythema multiforme have been reported in postmarketing experience. Treatment should be stopped and appropriate therapy instituted if an allergic-like reaction occurs or is suspected.
- There have been postmarketing reports (mostly from Japan) of delirium and abnormal behavior leading to injury, and in some cases resulting in fatal outcomes, in patients with influenza who were receiving oseltamivir.

Drug Interactions

Live attenuated influenza vaccine, intranasal:

- Do not administer until 48 hours following cessation of Oseltamivir.
- Do not administer Oseltamivir until 2 weeks following administration of the live attenuated vaccine, unless medically indicated.
- Oseltamivir is not a substrate for, or inhibitor of, cytochrome P450 isoenzymes.
- Clinically significant drug interactions are unlikely.

For more information …

Antiviral medication information from CDC: http://www.cdc.gov/flu/antivirals/

Relenza® – Full Prescribing Medication Package Insert: http://www.gsk.com/products/prescription-medicines/relenza.htm

Tamilfu® – Full Prescribing Medication Package Insert: http://www.rocheusa.com/products/tamiflu/pi.pdf

Attachment 2.2. Antiviral Medication – Medical Evaluation, Consent, and Prescribing

What medical problems have you had?		
☐**No**	☐**Yes**	Do you have allergies to any medications? List:
☐**No**	☐**Yes**	Do you have a history of kidney disease? Describe:
☐**No**	☐**Yes**	Are you allergic to Tamiflu® (oseltamivir) or Relenza® (zanamivir)?
☐**No**	☐**Yes**	Are you pregnant? If yes, what is your due date? ___/___/___
☐**No**	☐**Yes**	Are you planning on becoming pregnant within the next year?
☐**No**	☐**Yes**	Are you nursing (breast feeding)?
☐**No**	☐**Yes**	Do you have asthma or chronic obstructive pulmonary disease? (*Do not use Relenza*®.)
☐**No**	☐**Yes**	Do you have flu symptoms? If yes, check all that apply: ☐ fever ☐ cough ☐ shortness of breath ☐ sore throat When did your symptoms start? ___ hours ago ___ days ago
☐**No**	☐**Yes**	Have you been in contact with anyone who has flu symptoms? If yes, how long ago? ___ days
List medications that you currently take (medication/dose):		

Health Care Provider Only:

Patient has contraindications to antiviral therapy and is not approved. List reasons:

	Prescription for Tamiflu® (oseltamivir)	**Prescription for Relenza® (zanamivir)**
Influenza treatment	☐ 75 mg twice daily for 5 days ☐ Renal impairment: once daily for 5 days	☐ 10 mg (2 puffs) twice daily for 5 days
Influenza post-exposure prophylaxis	☐ 75 mg twice daily for 5 days ☐ Renal impairment: once daily for 5 days	☐ 10 mg (2 puffs) once daily for 10 days
Influenza prophylaxis (ongoing)	☐ 75 mg twice daily for ___ days ☐ Renal impairment: 75 mg once daily every other daily for ___ weeks	☐ 10 mg (2 puffs) once daily for ___ weeks

Provider signature and stamp: Date: ___/___/___

- I have been counseled regarding antiviral medication therapy. I am aware that in order to be eligible to receive antiviral medication, I must participate in medical evaluation.
- I have been advised to call my personal physician if signs and symptoms of the flu develop.
- I was offered the opportunity to ask questions during the visit. The medical information I provided above is complete and accurate to the best of my knowledge.
- I am aware that this medication is being prescribed for my personal use only, and that I am not to sell it or give it to anybody else.
- I am also aware that I am to contact my personal physician if any changes to my medical status occur, or if I am experiencing adverse effects from antiviral medication.

Patient signature: _____ Date: ___/___/___

Witness signature: _____ Date: ___/___/___

Institution	Identification

Attachment 2.3. Guidance for Acquisition, Storage, and Use of Antiviral Medication Procurement

Each regional HSA will maintain a stockpile of Tamiflu® and Relenza® per guidance from the BOP Medical Director.

Storage: Each regional HSA will designate a central storage facility within their respective region. Medication will be properly stored in accordance with the current Pharmacy Program Statement, PS6360.01. Each storage site will store product in a secured and proper temperature-controlled area, and will segregate pandemic stock from inventory intended for inter-pandemic use. Verification of proper storage temperature must be maintained on site.

Verification: On a quarterly basis, each regional HSA or designee is to complete the *Quarterly Pandemic Influenza Medication Certification* (*Attachment 2.4*). Certification will verify the quantity on hand, expiration date, and appropriate storage conditions (temperature). The original is to be maintained on site, with a copy forwarded to the BOP Chief Pharmacist or designee.

Restricted Use: Product cannot be dispensed for inter-pandemic use. Product may only be dispensed once Phase VI of the World Health Organization (WHO) influenza pandemic phase is declared by the WHO, as referenced in Section 1, Part V, of the *Pandemic Influenza Preparedness and Response Plan* issued by the U.S. Department of Health and Human Services in August 2004. A national and state-specific pandemic influenza declaration by the U.S. Department of Health and Human Services (ACDC@) will also allow release of product under this agreement. Only the BOP Medical Director can authorize the use of stockpiled medication. In the event of a pandemic outbreak, the Medical Director will issue written notice of authorized use.

Distribution: Each regional HSA will develop a plan to distribute medication from the stockpile site to individual institutions in the event of a pandemic outbreak, with staging at the direction of the BOP Medical Director or designee.

Dispensing: The BOP Medical Director will authorize dispensing and distribution of antiviral medication, once a pandemic is declared as defined above. Dispensing will occur by designated health care staff according to PS6360.01. A dispensing log will be maintained of all medication dispensed to inmates and staff and documented in BEMR. Once an influenza outbreak has been resolved, return unused antiviral medication to the Regional Office stockpile within 6 to 8 weeks.

Record Keeping: All records of procurement, storage, distribution, and dispensing must be kept on site for a period of at least five years beyond the purchase agreement terms. In the event of an audit, copies of all records will be requested to be sent to the Central Office within 10 days of request. A perpetual inventory will be maintained from procurement, through distribution and dispensing to the patient, documenting the appropriate chain of custody.

Attachment 2.4. Quarterly Pandemic Influenza Medication Certification

Region: _____ **Storage Facility:** _____

Date of Certification: ___/___/___ **Date of Last Certification:** ___/___/___

	Oseltamivir		Zanamivir	
	Quantity	Lot and Expiration Date	Quantity	Lot and Expiration Date
Beginning balance				
Quantity received (+)				
Quantity distributed, detail below (–)				
TOTAL ON HAND				

Antiviral Distributed			
Institution	**Date Sent**	**Quantity of Oseltamivir Sent**	**Quantity of Zanamivir Sent**

Antiviral Returned			
Institution	**Date Returned**	**Quantity of Oseltamivir Returned**	**Quantity of Zanamivir Returned**

I certify that the above quantities are correct and that all medication has been properly stored and secured, in accordance with manufacturer's recommendations and purchase agreement.

_____ _____ _____
Signature *Printed Name* *Title*

_____ _____ _____
Witness Signature *Printed Name* *Title*

Federal Bureau of Prisons
Health Services Division

Pandemic Influenza Plan

Module 4:
Care for the Deceased

October 2012

BOP Pandemic Influenza Response Stages

The BOP *Pandemic Influenza Plan* is divided into the three stages that are used for standard BOP contingency plans; in this plan, the three stages are designed to correlate with the Federal Government Response Stages for pandemic influenza.

The BOP Pandemic Influenza Response Stages are as follows:

- **PREPARATION** (Federal Response Stages 0–1). Most of the detail in this plan involves the preparation phase.
- **RESPONSE** (Federal Response Stages 2–5). This phase, which begins when it is announced that there are confirmed human outbreaks overseas, involves both making last-minute preparations and actually responding to pandemic flu.
- **RECOVERY** (Federal Response Stage 6). This phase involves recovering from the pandemic, evaluating actions taken during the pandemic, and preparing for more flu. Based on what we know from previous pandemics, subsequent waves of flu are likely to follow once the pandemic flu has subsided.

Federal Government Response Stages*		BOP Influenza Plan	
		Federal Stages	BOP Stage
0	New domestic animal outbreak in at-risk country	**0-1**	**PREPARATION**
1	Suspected human outbreak overseas		
2	Confirmed human outbreak overseas	**2-5**	**RESPONSE**
3	Widespread human outbreaks in multiple locations overseas		
4	First human case in North America		
5	Spread throughout United States		
6	Recovery & preparation for subsequent waves	**6**	**RECOVERY**

** The Federal Government Response Stages should not be confused with the World Health Organization phases of pandemic influenza.*

Table of Contents

Overview

In the event of a severe pandemic flu, it is anticipated that the services of community funeral homes and local medical examiners could become temporarily unavailable. In that instance, correctional facilities would have responsibility for the initial processing and storage of bodies of deceased inmates. Thus, the BOP Pandemic Influenza Planning Group decided that it was prudent to provide BOP facilities with detailed procedures for caring for the deceased.

The Department of Health and Human Services (DHHS) estimates that for a severe pandemic flu (akin to the 1918-19 pandemic), the death rate in the general community would be 6 deaths per 1000 persons who become ill. The DHHS estimate assumes that 30% of the population becomes sick with the flu and that 2% of those who become sick with pandemic flu die from it. Because of factors unique to the prison setting, this BOP pandemic flu plan assumes a higher death rate for a severe pandemic than that estimated for the general population. These factors include the close contact of inmates (increasing risk of flu transmission) and their high rates of other chronic, high risk medical conditions (increasing vulnerability to flu). Thus, in a "worst case scenario" for pandemic flu, the BOP estimates a death rate of 10 deaths per thousand inmates (1%).

This plan for "Care for the Deceased" includes the following elements:

- Communication with local health department and medical examiner about pandemic flu planning.
- Procedures for setting up a temporary morgue (if community resources become unavailable).
- Detailed procedures for care for the deceased, including lists of needed supplies.
- Provision of a form for identifying and tracking the deceased.

General guidelines for handling the deceased are provided in *Attachment 4.1*. Specific procedures for care for the deceased are outlined in *Attachment 4.2*, and the *Pandemic Flu Death Record/24-Hour Death Report* is available in *Attachment 4.3*.

This plan for "Care for the Deceased" is not designed to frighten; nor does it make a prediction about what will occur. Implementation of this plan will provide some assurance that if a pandemic flu "worst case scenario" occurs, the Bureau of Prisons will be prepared to handle the situation.

Action Steps by Pandemic Stage

Preparation (Federal Response Stages 0–1)
(See *Standard Operating Procedures*, which are provided for the Preparation stage only.)

1. Identify a staff person to be responsible for planning for care for the deceased.
2. Estimate the number of inmate deaths in a pandemic flu "worst case scenario."
3. Communicate with the local health department and medical examiner's office about plans regarding care for the deceased in a pandemic in the local community.
4. Develop local facility plans for care for the deceased. Review *Attachment 4.1, General Guidelines for Handling the Deceased.*
   a. Plan for a temporary morgue (including a place for bodies to be processed and a refrigerated place for storage).
   b. Plan for needed supplies.
   c. Review *Attachment 4.2, Procedures for Care for the Deceased,* and adapt it to this facility.
   d. Review *Attachment 4.3, Pandemic Flu Death Record/24-Hour Death Report,* and adapt it to this facility.
   e. Develop a facility-specific procedure for tracking the location of the deceased.
   f. Discuss possible storage plans in the event that refrigeration is not feasible.

Response (Federal Response Stages 2-5)

Begin when there are confirmed human outbreaks of pandemic flu anywhere in the world:

1. Contact local funeral home(s) and the medical examiner to assess potential availability of services.
2. Review plans and procedures, the location for a temporary morgue, the adequacy of refrigerated space, and assure availability of needed supplies.

After a pandemic death occurs in the facility:

3. Contact local funeral homes and/or the medical examiner to handle inmate deaths per usual facility procedures.
4. If community resources become unavailable, set up a temporary morgue and implement *Attachment 4.2, Procedures for Care for the Deceased.*

Recovery (Federal Response Stage 6)

Previous flu pandemics have been associated with subsequent "waves" of flu after an initial wave resolves. After an initial pandemic flu outbreak, subsequent outbreaks are likely. The recovery period will involve both recovering from the pandemic emergency, evaluating the BOP response to it and preparing for subsequent waves of pandemic flu.

1. Assess adequacy of response to an increased number of the deaths in the facility.

2. Prepare written summary of response.

Module 4: Care for the Deceased
Standard Operating Procedures for Preparation Stage
(Federal Response Stages 0–1)

During the Preparation stage, adapt this Standard Operating Procedure template to the unique circumstances of your facility. A modifiable Word version is posted on: www.bop.gov/news/medresources.jsp.

1. Identify a staff person to be responsible for planning for care for the deceased.

In this facility, the following individual is assigned responsibility:

2. Estimate the number of inmate deaths in a pandemic flu "worst case scenario."

Estimation formula: Total number of inmates housed in the facility multiplied by 0.01 (1%).
Total # inmates housed in this facility: _____ x 0.01 = _____ = estimated # inmate deaths

3. Communicate with the local health department and medical examiner's office about plans regarding care for the deceased in a pandemic in the local community.

a. Contact the local health department and/or medical examiner to learn about local pandemic flu plans for care for the deceased.

Medical Examiner:

Address:

Phone:

Are there any plans for mass storage of bodies? ☐ Yes ☐ No
If yes, what?

Are there any local requirements for reporting of pandemic deaths? ☐ Yes ☐ No
If yes, what?

b. Identify funeral home(s) currently utilized and assess their plans for pandemic flu.

Funeral Home:	Funeral Home:
Address:	Address:
Phone:	Phone:

Do they have any plans for expanding services in the event of a pandemic? ☐ Yes ☐ No
If yes, what?

If yes, is transportation likely to be available? ☐ Yes ☐ No

Is it likely that the institution will be required to transport bodies? ☐ Yes ☐ No

4. Develop facility-specific plans for care for the deceased. Review *Attachment 4.1, General Guidelines for Handling the Deceased.*

a. Plan for a temporary morgue.

Identify a place in this facility where bodies could be processed:

Identify a refrigerated place in this facility to store human remains:

Note: *The ideal temperature for storing and preserving human remains is between 34–37°F. Ideally, bodies should not be stacked on top of each other to avoid distortion of features and to facilitate moving them.*

b. Plan for needed supplies.

Review the supply list below and identify how much of each item would be needed for your facility based upon estimated number of deceased inmates. Determine if the facility should stockpile these supplies separately or if adequate supplies would be on-hand.

Amount	Item
	Body bags (number based on 1% of inmate population)
	Gloves*
	N-95 respirators*
	Gowns*
	Eye protection*
	Hand hygiene supplies*
	8½" x 11" plastic sleeves (2 per deceased) to protect paperwork
	Waterproof, clear tape (to seal plastic sleeves)
	Wash cloths and towels (for cleaning and padding)
	Clear plastic bags (for personal effects)
	Strips of material (to tie legs together)

* to be stockpiled as part of *Module 1: Surveillance & Infection Control*

In this facility, the following plan will be followed for securing supplies for care for the deceased:

c. Review *Attachment 4.2, Procedures for Care for the Deceased,* and adapt it to this facility.

d. Review *Attachment 4.3, Pandemic Flu Death Record/24-Hour Death Report,* and adapt it to this facility.

e. Develop a facility-specific procedure for tracking the location of the deceased, i.e., a line-listing of deceased inmates and their current location; or a notebook containing Pandemic Flu Death Records—each indicating current location of the deceased inmate's body. In this facility, the following procedure will be utilized to track the location of deceased inmates:

f. Discuss possible storage plans in the event that refrigeration is not feasible, i.e., temporary burial. Document possible strategies:

Attachment 4.1. General Guidelines for Handling the Deceased

General Facts

Those attending to the deceased are at much greater risk of contracting pandemic flu from exposure in the general community or through contact with someone who is ill with pandemic flu, than from contact with the deceased.

- Dead bodies do not cause epidemics.
- Use *Standard Precautions* when in contact with blood or body fluids, including good hand washing.

Infection Control Measures

Individuals who are assigned to transport and care for the deceased should be provided the following information and necessary protective equipment.

- Routinely wear single layer gloves and an N-95 respirator.
- Prior to handling the body, place a face mask over the nose and mouth of the deceased to prevent inhalation of residual air that may be expelled from the lungs when the body is moved. Remove the mask before closing the body bag.
- If risk of splash or spray from blood/body fluids, wear a protective gown and eye/face barrier.
- Do not smoke, eat, or drink when handling the body.
- Avoid wiping your eyes, mouth, or nose with your hands.
- Remove all personal protective equipment after handling each body, and wash hands well.
- Decontaminate all surfaces and any equipment used to transport the dead body with an Environmental Protection Agency (EPA)-registered disinfectant: http://www.epa.gov/oppad001/chemregindex.htm

Additional Instructions

- Keep movement of the head of the body to a minimum.
- Do not spray or place disinfectant on the body.
- Do not write identifiers on the body or on the body bag, as they may erase. Use proper labeling technique on the inside and outside of the body bag.
- Carefully place the body in a standard body bag or large plastic bag. Seal the bag.
- Lay bodies in one layer only (not on top of each other).
- Track all morgue admissions and releases.

Storage Considerations

Refrigerate between 34–37 degrees F (2–4 degrees C). If refrigeration is not available, alternative short-term options include: (1) dry ice (not directly on body), with good ventilation (melted “carbon dioxide” is toxic) and safe handling techniques (to prevent “cold burns”); or (2) temporary burial. Coordinate locally and seek expert guidance. Establish procedures prior to the pandemic.

Cultural and Religious Practices

Cultural and religious needs should be respected. Involve chaplains in the identification and accommodation of religious rituals related to rites of passage (e.g., Islamic ritual of turning the head toward Mecca).

Attachment 4.2. Procedures for Care for the Deceased

The procedures below should be utilized if mortuary services are unavailable.

1. **Prepare documentation.**
   a. **Fill out the information requested in *Attachment 4.3*, *Pandemic Flu Death Record/24-Hour Death Report*.**
      Note: The use of Attachment 4.3 will serve multiple purposes: provide local BOP facility with a record of the death; provide record of the location where the body is stored; provide documentation to maintain with the body; and serve as the BOP 24-Hour Death Report.
   b. **Make 3 copies. Place 2 copies in plastic sleeves**, sealed with transparent tape.
   c. **Maintain 1 copy in notebook or file** (optionally, maintain an electronic copy).
2. **Follow notification procedures** (P5553.07 "9. Death Notification Procedures").
3. **Verify identity** (PS5800.13.903 (Deaths)). "ISM staff or designee will verify the inmate's identity by taking a rolled print of the right thumb. A comparison of the print will be made with the fingerprint card in the Inmate Remand or J&C file."
4. **Use preliminary infection control measures** (see *Attachment 4.1*).
   a. **Wash your hands.**
   b. **Put on personal protective equipment.** (Routinely wear gloves and an N-95 respirator. If risk of splash/ spray from blood/body fluids, wear gown and eye/face barrier.)
   c. **Place a face mask on deceased** (covering mouth and nose) prior to transporting.
5. **Prepare the body.**
   a. Straighten the dead person's body and close the eyelids without using any force.
   b. Close the person's mouth by placing a rolled towel under the chin.
   c. Remove all IV lines, monitors, and other equipment.
   d. Bathe any part of the body that is soiled with blood or other body fluids.
   e. Remove any soiled dressings and replace.
   f. Remove jewelry and/or glasses. Ensure dentures are in the person's mouth.
   g. Document any jewelry or other effects removed.
   h. Pad the wrist and ankles with a rolled up washcloth and tie them loosely together.
6. **Attach documentation of identity to the body.**
   a. Attach BOP identification card to the right toe utilizing plastic twist-tie.
   b. Attach copy of the Pandemic Flu Record (in plastic sleeve) to the right wrist.
   c. Attach copy of the Pandemic Flu Record (in plastic sleeve) to the outside of the body bag.
7. **Place the body inside the body bag.**
   a. Ensure that the bag is fully sealed and that no body fluids are leaking.
   b. Ensure that the outside of the bag is clean.
   c. Put clothing and personal effects in a separate plastic bag.
   d. Place the bag of personal effects inside the body bag with the body.
8. **Carry out follow-up infection control measures.**
   a. Properly dispose of any soiled or used material.
   b. Remove gloves properly.
   c. Wash hands thoroughly.

Attachment 4.3. Pandemic Flu Death Record/24-Hour Death Report

Facility Name: *Address:* *Phone:*		
Last Name:	**First Name:**	**MI:**
Reg #:	**Date of Birth:** ___/___/___	**Date of Death:** ___/___/___
Place of Death: ☐ Institution, in: ☐ General Population ☐ SHU ☐ Medical Unit ☐ Behavioral Health Unit ☐ Community Hospital ☐ Other		
Type of Death: ☐ Natural cause ☐ Suicide ☐ Accidental ☐ Homicide ☐ Legal Execution ☐ Unknown **DNR Order?** ☐ Yes ☐ No **Autopsy?** ☐ Yes ☐ No		
Preliminary Cause of Death:		
Clinical Synopsis of Events Leading to the Death (including clinical care provided): *(continue on following page if more room needed)*		
Location of Body: (1)		Date:
(2)		Date:
(3)		Date:
Next of Kin: _____ Notified? ☐Y ☐ N Address: _____ _____ Phone: _____		**Religion of deceased:** _____ Religious ritual requirements?
Personal effects accompanying body (list all):		
Staff person completing report:		
Name (print):		Title:
Signature:		Date:
Note: This document serves the following purposes: (1) provides local BOP facility with a record of the death; (2) provides record of the location where the body is stored; (3) provides documentation to maintain with the body; and (4) serves as the BOP 24-Hour Death Report.		**Form instructions:** Make 3 copies, placing 2 in sealed plastic sleeves. Attach 1 sealed copy to right wrist of inmate; secure 1 sealed copy to the outside of body bag; and maintain 1 copy on file.

CORONAVIRUS DISEASE 2019 (COVID-19) STAFF SCREENING TOOL

DATE:_____

1. Temperature: _____ °F Method: Mouth Ear Forehead

□ If Temperature (Mouth) ≥ 100.4°F, or Temperature (Ear) ≥101°F, or Temperature (Forehead) ≥ 100°F

Then Deny Access , Place on Leave (Not Safety & Weather Leave) for 3 days + STOP HERE & Proceed to Section 3

2. Signs (Employee Complete)

□ Yes □ No	**New On-Set Cough** # of Days_____
□ Yes □ No	**New Onset Trouble Speaking because of Needing to take a Breath**
□ Yes □ No	**Stuffy/Runny Nose**

- Contact the Medical Officer on Call for the Institution to provide Disposition
  - ✓ Disposition by Medical Officer Assessment:
    - □ Leave
    - □ Work

3. Notification of Local Human Resources Department

□ If Individual is placed on leave for Section 1 *or* 2, Then share document with HR Office for T&A purpose

- **HR**

□ Please have HSD place this document in the Employee's Medical Folder (Blue Folder) if leave is indicated

Staff Name (Last, First): _____ **Year of Birth (Year):** _____

Institution: _____ **State:** _____

U.S. Department of Justice
Federal Bureau of Prisons

P R O G R A M S T A T E M E N T
OPI: HSD/HPB
NUMBER: 6031.04
DATE: June 3, 2014

Patient Care

/s/
Approved: Charles E. Samuels, Jr.
Director, Federal Bureau of Prisons

1. PURPOSE AND SCOPE

To effectively deliver medically necessary health care to inmates.

a. Summary of Changes

Policy Rescinded
P6031.03 Patient Care (8/23/12)

The following changes were made:

- Section 15. Added language on the ordering of chronic care medications.
- Section 18. Replaced use of BP-A0659 (Medical Summary of Federal Prisoner/Alien In Transit) with BEMR Exit Summary for Inmate Intra-system Transfer.
- Section 20. Clarified schedule for performing baseline mammographies.

2. PROGRAM OBJECTIVES

The expected result of this program is:

Health care will be delivered to inmates in accordance with proven standards of care without compromising public safety concerns inherent to the agency's overall mission.

3. **DIRECTIVES REFERENCED**

Program Statements

P1070.07	Research (5/12/99)
P1351.05	Release of Information (9/19/02)
P3735.04	Drug Free Workplace (6/30/97)
P4500.09	Trust Fund/Deposit Fund Manual (1/13/14)
P4700.06	Food Service Manual (9/13/11)
P5050.49	Compassionate Release/Reduction in Sentence; Procedures for Implementation of 18 U.S.C. §§ 3582(c)(1)(A) & 4205(g) (8/12/13)
P5280.09	Inmate Furloughs (1/20/11)
P5324.09	Sexually Abusive Behavior Prevention and Intervention Program (8/20/12)
P5324.08	Suicide Prevention Program (4/5/07)
P5521.05	Searches of Housing Units, Inmates, and Inmate Work Areas (6/30/97)
P5553.07	Escapes/Deaths Notifications (2/10/06)
P6010.03	Psychiatric Evaluation and Treatment (8/12/11)
P6010.04	Health Services Administration (6/20/13)
P6013.01	Health Services Quality Improvement (1/15/05)
P6027.01	Health Care Provider Credential Verification, Privileges, and Practice Agreement Program (1/15/05)
P6070.05	Birth Control, Pregnancy, Child Placement and Abortion (8/9/96)
P6080.01	Autopsies (5/27/94)
P6090.03	Health Information Management (7/31/12)
P6190.04	Infectious Disease Management (6/2/14)
P6270.01	Medical Designations and Referral Services for Federal Prisoners (1/15/05)
P6340.04	Psychiatric Services (1/15/05)
P6360.01	Pharmacy Services (1/15/05)
P6370.01	Laboratory Services (1/15/05)
P6400.02	Dental Services (1/15/05)

Code of Federal Regulations, Chapter 29, Part 1910.95

4. **AGENCY ACA ACCREDITATION PROVISIONS**

- Standards for Adult Correctional Institutions, 4th Edition: 4-4322M, 4-4344M, 4-4346, 4-4347, 4-4348, 4-4349, 4-4350, 4-4351M, 4-4352, 4-4353M, 4-4354M, 4-4359M, 4-4360, 4-4362M, 4-4363M, 4-4365M, 4-4367, 4-4370M, 4-4374, 4-4375, 4-4377, 4-4380M, 4-4381M, 4-4382M, 4-4389M, 4-4397M, 4-4398, 4-4400M, 4-4401M, 4-4402M, 4-4412, 4-4426, and 4-4427

- Performance-Based Standards for Adult Local Detention Facilities, 4th Edition: 4-ALDF-2A-45M, 4-ALDF-4A-13M, 4-ALDF-4C-01M, 4-ALDF-4C-03, 4-ALDF-4C-04, 4-ALDF-4C-05, 4-ALDF-4C-06, 4-ALDF-4C-08M, 4-ALDF-4C-09, 4-ALDF-4C-13M, 4-ALDF-4C-19M, 4-ALDF-4C-20, 4-ALDF-4C-22M, 4-ALDF-4C-23M, 4-ALDF-4C-24M, 4-ALDF-4C-26, 4-ALDF-4C-27, 4-ALDF-4C-29M, 4-ALDF-4C-34, 4-ALDF-4C-35, 4-ALDF-4C-37, 4-ALDF-4D-01M, 4-ALDF-4D-02M, 4-ALDF-4D-03M, 4-ALDF-4D-15M, 4-ALDF-4D-16, 4-ALDF-4D-17M, and 4-ALDF-4D-18M

- Standards for Administration of Correctional Agencies, 2nd Edition: 2-CO-1F-14

Records Retention Requirements

Requirements and retention guidance for records and information applicable to this program are available in the Records and Information Disposition Schedule (RIDS) system in Sallyport.

5. **DEFINITIONS**

a. **Health Services Unit (HSU).** The HSU is the organizational unit that provides urgent and routine health care. In addition, the HSU is the designated part of an institution, including Medical Referral Centers (MRC) that delivers health care to inmates on an ambulatory or observation basis. The provision of health care is subdivided into:

- Urgent Services.
- Observation Services.
- Ambulatory Care Services.

b. **Outpatient Clinic.** This area within the HSU provides diagnostic and other support services health care staff uses to provide urgent care and ambulatory care services. It includes examination rooms, treatment rooms, dental clinic, radiology and laboratory areas, pharmacy, waiting areas, and administrative offices.

c. **Observation Area.** The observation area provides accommodations of limited duration for inmates who are being treated for noncritical illnesses, recovering from surgery, or require observation, and who do not require acute care hospitalization or 24-hour nursing care.

d. **Medical Referral Center (MRC).** An MRC provides a full range of diagnostic and therapeutic services, consistent with its individual mission; and a wide range of inpatient specialty consultative and other services. **Inpatient services are available only at MRCs.**

The Medical Director will designate each MRC's mission(s). Each MRC will seek and maintain accreditation by the Joint Commission for the Accreditation of Healthcare Organizations under appropriate standards in accordance with its mission. Unless Bureau policy specifies otherwise, MRCs will organize their programs to comply with Joint Commission standards.

e. **Primary Care Provider Team (PCPT).** A PCPT is a core group of health care providers and support staff whose function is to provide direct patient care.

f. **Advance Directive.** For purposes of this PS, an "advance directive" is a written instrument (sometimes referred to as a "living will" or other similar document) by which a patient expresses his/her health care wishes in the event of a terminal or irreversible condition, during which that individual is no longer able to communicate such wishes to the health care provider due to incapacitation.

Advance directives may address the patient's wishes concerning the withholding or withdrawal of resuscitative, life-sustaining, or other types of medical care.

Advance directives may appoint a proxy decision maker for these type health care decisions.

g. **Proxy Decision Maker.** For purposes of this PS, a proxy decision maker is a person authorized to make healthcare treatment decisions for a patient who is incapacitated and unable to make and/or communicate such decisions himself/herself. The term "proxy decision maker" is used generally in this PS, and may refer to such person as named in an advance directive, formally executed power of attorney, or as appointed by a court.

The authority, parameters, and procedures for creating such proxies are governed by the laws of the state in which the institution operates.

Under no circumstances will another inmate be appointed as proxy decision maker.

h. **Life Sustaining or Life Prolonging Procedures.** "Life sustaining" or "life prolonging" procedures include any medical intervention or procedure that uses artificial means to sustain a vital function or artificially prolong life, e.g. mechanical ventilation, dialysis.

i. **Terminal Condition.** A "terminal condition" means an incurable or irreversible medical condition which, in the attending physician's opinion, is such that death will occur within a short time regardless of the application of medical procedures.

j. **"Do Not Resuscitate" (DNR) Order.** A "Do Not Resuscitate" order is the attending physician's directive, recorded in the inmate's health record, to withhold or withdraw extraordinary life-sustaining measures.

6. PROGRAM RESPONSIBILITY

Clinical care of inmates at Bureau institutions is under the direction of the Clinical Director, who provides direct patient care and supervises other health care providers. Administrative responsibility and supervision of non- clinical staff is under the Health Services Administrator's (HSA) direction.

7. SCOPE OF SERVICES – CATEGORIES OF CARE

The Bureau of Prisons provides five major levels of care that define care provided to inmates.

Note: Ordinarily, pretrial or non-sentenced inmates, and inmates with less than 12 months to serve, are ineligible for health services in subsections c., d., and e.

a. **Medically Necessary – Acute or Emergent.** Medical conditions that are of an immediate, acute or emergent nature, which without care would cause rapid deterioration of the inmate's health, significant irreversible loss of function, or may be life-threatening.

Examples of conditions considered acute or emergent include, but are not limited to:

- Myocardial infarction.
- Severe trauma such as head injuries.
- Hemorrhage.
- Stroke.
- Status asthmaticus.
- Precipitous labor or complications associated with pregnancy.
- Detached retina, sudden loss of vision.

Treatment for conditions in this category is essential to sustain life or function and warrant immediate attention.

b. **Medically Necessary – Non-Emergent.** Medical conditions that are not immediately life-threatening but which without care the inmate could not be maintained without significant risk of:

- Serious deterioration leading to premature death.
- Significant reduction in the possibility of repair later without present treatment.
- Significant pain or discomfort which impairs the inmate's participation in activities of daily living.

Examples of conditions considered medically necessary, non-emergent include, but are not limited to:

- Chronic conditions (diabetes, heart disease, bipolar disorder, schizophrenia).
- Infectious disorders in which treatment allows for a return to previous state of health or improved quality of life (HIV, tuberculosis).
- Cancer.

c. **Medically Acceptable – Not Always Necessary.** Medical conditions which are considered elective procedures, when treatment may improve the inmate's quality of life. Relevant examples in this category include, but are not limited to:

- Joint replacement.
- Reconstruction of the anterior cruciate ligament of the knee.
- Treatment of non-cancerous skin conditions (e.g. skin tags, lipomas).

These therapeutic interventions always require review by the Institution Utilization Review Committee. Relevant factors to consider in approving the proposed treatment in this category include, but are not limited to:

- The risks and benefits of the treatment.
- Available resources.
- Natural history of the condition.
- The effect of the intervention on inmate functioning in his/her activities of daily living.

d. **Limited Medical Value.** Medical conditions in which treatment provides little or no medical value, are not likely to provide substantial long-term gain, or are expressly for the inmate's

convenience. Procedures in this category are usually excluded from the scope of services provided to Bureau inmates. Examples in this category include, but are not limited to:

- Minor conditions that are self-limiting.
- Cosmetic procedures (e.g. blepharoplasty).
- Removal of non-cancerous skin lesions.

Any treatment in this category which a health care provider recommends and the Clinical Director feels is appropriate will require the Institution Utilization Review Committee's review.

e. **Extraordinary.** Medical interventions are deemed extraordinary if they affect the life of another individual, such as organ transplantation, or are considered investigational in nature.

Any treatment provided in this category requires the Medical Director's review and approval with notification to the Regional Director.

8. **UTILIZATION REVIEW**

Every institution will have an established Utilization Review Committee (URC), chaired by the Clinical Director. Other members should include, but not be limited to the:

- HSA or Assistant HSA.
- Medical Trip Coordinator.
- Health care provider(s) directly involved in the reviewed cases.
- Director of Nursing (if applicable).
- A chaplain or social worker.

The URC will review the following areas:

- Outside medical, surgical, and dental procedures.
- Requests for specialist evaluations, in-house or escorted trips to the specialist's office (approved by the Clinical Director).
- Requests for "Limited Medical Value" treatments/procedures (approved by the CD).
- Retrospective review of all cases sent to the community hospital during hours when no health care provider was on duty at the institution.
- Case considerations for extraordinary care.
- Concurrent review of inpatients at community hospital (monitoring length of stay and interventions).
- Other services the primary care provider or the Clinical Director have recommended.

Note: Care considered "Medically Necessary – Acute or Emergent" does not require URC review prior to the treatment being provided.

a. **Recommendations.** The URC must select one or more of the following, to address each case presented to it:

- Approve the request without modification.
- Refer the inmate for further evaluation to a staff physician.
- Refer the inmate for further evaluation to a specialty consultant.
- Put the inmate on a waiting list, with recommended parameters as to the length of time the procedure may be delayed without increasing the risk of additional morbidity.
- Determine that the procedure is contraindicated, due to unacceptable risk to the inmate if it is performed.
- Deny the request for the procedure.

b. **Decisions.** As chair of the committee, the Clinical Director is the final authority for all URC decisions.

The CD will notify inmates in writing when URC decisions are made with a copy of the notification placed in the inmate's health record. The reason for the decision should be indicated where applicable.

The CD is under no obligation to follow consultant recommendations. If the recommendations are not followed, the CD will document his/her justification in the inmate health record.

If a specific intervention is not pursued, the inmate will be advised that his/her condition will continue to be monitored and ongoing treatment provided as necessary, and that re-submission of the request will be considered if medically indicated.

c. **Secondary Reviews.** The Clinical Director may request a secondary review for treatments or procedures in the categories of "**Medically Acceptable – Not Always Necessary**" and "**Limited Medical Value**" on a case-by-case basis through the regional Clinical Specialty Consultants or a Central Office physician. The CD will document such discussions in the inmate health record.

d. **Pre-certification.** The Medical Director may periodically require pre-certification (prior approval) for certain types of cases (e.g. high risk, high cost, or questionable efficacy). Institutions will be notified by memorandum when pre- certification requirements are in effect.

e. **Retrospective Review.** Institutions should consider a retrospective review of emergency cases based on URC findings as part of the institution Quality Improvement Program.

9. **EMERGENCY/URGENT CARE**

Each institution will have an Institution Supplement for providing 24 hour medical, dental and mental health care. Each supplement will include procedures for notifying the HSU for initial assistance, screening and, if appropriate, subsequent transfer of the inmate(s) to the HSU or to external emergency facilities. The procedures will address:

- Arrangements for on-site first aid and crisis intervention.
- Use of one or more HSU urgent treatment rooms or other facilities.
- Use of the HSU emergency medical vehicle for transporting inmates across the compound.
- Appropriate method of transfer of the inmate from the institution to a community medical facility.
- Provision of emergency treatment in the absence of 24 hour on-site medical coverage.
- Emergency on-call procedures for hours that health care providers are not on-site.

ACA standards require a four-minute response to life- or limb-threatening medical emergencies.

Institutions without 24-hour on-site medical coverage, or those with multiple facilities separated by significant distance, are required to have procedures incorporated into the institution supplement by which this ACA standard can be met.

A team of "first responders" should be established for each shift, with documented training in first aid and CPR. Numbers on each team, and the designation of team members, will be negotiated locally:

- Use of one or more designated hospital emergency rooms or other appropriate facilities.
- Emergency on-call physician, dentist, and mental health professional services when the emergency health facility is not located in a nearby community.
- Security procedures providing for the immediate transfer of inmates when appropriate.

The HSU will conduct two emergency disaster drills per year. All drills will be critiqued to identify deficiencies and opportunities to improve. Documentation will be maintained in the HSA's office.

At MRC's, compliance with ACA and Joint Commission standards will be considered sufficient to meet the above requirements.

All health care practitioners, including HSAs and AHSAs, and Lieutenants will maintain CPR and Automated External Defibrillator (AED) certification. The HSA will be responsible for

maintenance and supplies (unexpired pacing pads/electrodes) for the AED according to the manufacturer's recommendations. Other staff may request CPR/AED training.

Annual review of the above supplement will be done during initial orientation to the HSU and annually thereafter.

Annual review of this supplement will be considered as part of in-house Continuing Professional Education.

10. **OBSERVATION SERVICES**

Institutions may provide limited observation bed space. These beds are not used in lieu of transfer to a community hospital or MRC. Observation beds will only provide limited outpatient services for short stay inmates.

Observation beds are located in the HSU. Neither patient examination rooms nor the Urgent Care Room will be used as observation rooms. Inmates placed on observation status **do not** require medical treatment(s) normally provided in an MRC or community hospital setting.

a. **Written Procedures Required.** Each institution using observation beds will have written procedures delineating their use, conforming to this policy. These policies will include procedures for:

- Designation of physical location of observation beds.
- Evaluation.
- Level of care provided.
- Supervision requirements.
- Release of inmates from observation beds.
- Sight and sound requirements (i.e. nurse call systems or visual monitoring systems).
- Direct observation every 30 minutes.

If the sight and sound requirements cannot be met by call buttons, electronic monitoring, or direct observation, then observation beds will not be used.

b. **Operations.** Observation rooms may only be used in accordance with the following:

- Only a physician may authorize their use when the room is used for medical observation. (If the room is used for suicide prevention, all requirements of the Program Statement **Suicide Prevention Program** apply).

- The Clinical Director will notify the Warden and other appropriate institution staff of the inmate's observation status.
- The CD will advise the Warden on the inmate's medical status and monitoring recommendations.
- The institution will have a plan to transfer the inmate to a community hospital in an emergency situation.
- The inmate will be oriented to life safety and fire evacuation procedures of the unit.

c. **Initiation and Discontinuation.** The following procedures apply to the initiation and discontinuation of observation status.

- A physician must be on call 24 hours per day.
- A physician will write an order on the Chronological Record of Medical Care (SF-600) admitting an inmate to observation status.
- When the physician authorizes use of medical observation telephonically, the physician must evaluate the inmate personally within four hours.
- All encounters between the inmate on observation and a health care provider will be recorded on an SF-600 form.
- Vital signs (temperature, blood pressure, pulse, respiration, pulse oximetry, if indicated) will be ordered by the physician and recorded on any inmate upon initiation of observation status, and daily thereafter, or as clinically indicated.
- Other diagnostic procedures such as laboratory tests, radiographs, etc. will be ordered, as indicated, by the physician.
- The Medical Duty Officer/physician on call will evaluate the inmate personally once daily, including weekends and holidays.
- Observation status may only be discontinued by a physician, ideally by the same physician who authorized the observation.

d. **Appropriate Use.** HSU observation rooms may be used in cases that do not require 24-hour nursing care, such as an inmate recovering from a surgical procedure in the local community, or to ensure that an inmate is prepared properly for a medical/dental procedure. Examples of appropriate observation room use include:

- Preparation of inmates for diagnostic studies such as upper/lower G.I. series, fasting purposes, etc.
- Upon return from out-patient surgery to assist adjustment in use of crutches, cane, casts, etc. Control of pain associated with known kidney stones.
- 24-hour urine collection, e.g. if the urine requires refrigeration.
- Ruling out infectious hepatitis (hepatitis A) requires isolation procedures.

- Routine postoperative care such as indwelling catheters (status post prostate surgery), or surgical drains.

A physician will review the need for continued observation after the first 24 hours. Inmates may only remain in observation status for 72 hours.

Observation rooms will **never** be used (not all inclusive):

- To rule out myocardial infarction.
- For inmates suddenly incontinent of bowel or urine.
- To rule out stroke.
- For acute mental health changes.
- For mental health diagnoses (placement of a mental health inmate in a locked room constitutes seclusion and other requirements apply).
- For reasons that may be deemed punitive such as restricting the inmate from recreation and other activities due to continued complaints such as back pain, etc.

11. NEGATIVE PRESSURE ISOLATION ROOMS (NPIR)

Infectious Disease Isolation Rooms are negative air pressure-capable rooms constructed and operated in accordance with Centers for Disease Control (CDC) guidelines.

The CD will determine the length of stay for an inmate assigned to negative pressure isolation with tuberculosis, chickenpox, herpes zoster, or other infections requiring air-borne precautions.

The CD will consult with the Medical Director for guidance on medications, length of stay, and contact investigations. See the Program Statement on Infectious Disease Management.

The Medical Director will determine which institutions must maintain certified Negative Pressure Isolation Rooms.

Institutions without these rooms will have a local procedure for immediate transfer of inmates with suspected active tuberculosis or other highly contagious airborne diseases to a community hospital or other BOP institution within close proximity with NPIR capability.

12. AMBULATORY CARE SERVICES

Each institution will have written policies and/or procedures for providing ambulatory care services. Procedures for the Outpatient Department will include at least:

- Management of inmates with mental illnesses or disorders.
- Patient privacy.
- Infection control.
- Poison control.
- CPR.
- Patient triage/sick call procedures.
- Medical duty status.
- Treatment of patients in special housing units and detention status.
- Intake screening.
- Urgent treatment.
- Staffing (describing implementation of the PCPT model).
- Chronic care clinics.
- Accident reporting.
- Advance directives.
- Autopsies.
- EKG (including procedures to obtain stat interpretations).
- Physical examinations.
- Eyeglasses.

a. **Primary Care Provider Teams.** The PCPT is designed to improve health care services delivery by enhancing continuity of care and promoting preventive health care measures. The PCPT is designed to function in the same manner as a medical office in a community setting. Under the PCPT model, each inmate is assigned to a medical team of health care providers and support staff who are responsible for managing the inmate's health care needs.

Assigning inmate caseloads to PCPTs will provide less duplication of services because team members will be more familiar with the medical problems of inmates assigned to the team.

Adequate numbers of mid-level providers (MLP) need to be available to provide diagnostic and treatment services to the inmate population during the typical weekday hours when the bulk of health care is delivered in our institutions.

For this model to be effective, teams are designed with support staff, such as nurses, medical assistants, health information technicians, and medical clerical staff, to perform duties and services which support the MLPs and physicians as they see their patients in the clinic.

Virtually all patient care provided to inmates will be by appointment, scheduled several days to weeks in advance through requests from the inmate, or follow-up appointments determined by the providers. When fully implemented, "sick call" will be eliminated (see Section 17).

Administrative facilities [Metropolitan Correctional Centers (MCC), Metropolitan Detention Centers (MDC), Federal Detention Centers (FDC), the Federal Transportation Center (FTC)] and MRCs, although not required, may establish PCPTs. The staffing pattern and provider/inmate ratios may be different based on patient acuity levels at administrative facilities.

Administrative and non-clinical functions supporting the HSU (e.g. budget, infection control, quality improvement activities, pharmacy services, laboratory and x-ray services and the ordering of supplies) will be performed by staff other than PCPT staff.

PCPT staff may participate in HSU committees and meetings which relate to patient care.

Appropriate levels of support staff must be achieved when implementing PCPT.

Institutions are to assign inmates to health care providers fairly and equitably. The method of assigning inmates will be negotiated locally.

Achieving this model will occur at different rates for different institutions. Factors affecting this rate of change include:

- Current staffing patterns.
- Unique institution missions and populations.
- Staff attrition.
- Ability to recruit and retain the desired mix of staff.
- Adequate administrative support staff.
- Adequate numbers of examination rooms, consultant rooms, equipment, etc.

Each institution must develop a contingency plan to address staff shortages which may occur after implementation of PCPT. Implementation will be negotiated locally.

When implementing the PCPT model, the following general guidelines should be considered for existing institutions:

(1) **Staffing Pattern**. Each institution will assess the current health services staffing pattern and restructuring plan. For example, a day shift PCPT staffing pattern for 1,000 general population inmates will have one physician, three mid-level practitioners, a registered nurse, one or two licensed practical nurses and/or medical assistants, two health information technicians, and a medical clerical staff person. Based on this example, each MLP would be assigned a caseload of approximately 330 inmates.

Insufficient staffing will have an adverse effect on the quality, continuity, and cost-effectiveness of health care.

Additional staffing will be required to provide health care services after hours and on weekends.

Additional staff and posts will be required for most satellite camps as well as satellite FDCs and WITSEC Units.

The provider-to-inmate ratio may also need to be adjusted depending on institution's security level, physical layout, and mission.

For a 1,000-bed female institution, one additional mid-level practitioner and one additional female clinical support person for chaperone purposes will be required.

(a) **Physician**. A physician will provide clinical oversight for multiple provider teams. The physician, as the licensed provider of the team, is responsible for the care that team delivers. As such, it is the physician's responsibility:

- To consult with the other team members.
- To provide training and mentoring.
- To directly evaluate and treat severely ill and medically complex inmates.

While the MLP is the PCPT's primary care provider, physicians are also responsible for providing direct patient care. Physicians will medically manage inmates with complex conditions on an ongoing basis notwithstanding the assignment of that inmate to an MLP. (Refer to Section 15 for discussion of the physician's role and referral procedures for complex conditions).

(b) **Mid-level Practitioner (MLP).** The MLP will serve as the primary point of contact for inmates assigned to their caseload. They will serve as the primary provider for:

- Routine requests for evaluation of new complaints.
- Ongoing management of reoccurring conditions.
- Emergencies when clinically indicated.

Refer to Section 15 for the MLP's role in Chronic Care Clinics.

(c) **Clinical Nurse (RN)**. When the PCPT model is implemented, the Clinical Nurse will serve as the coordinator for the out-patient area. Duties will include but not be limited to:

- Managing patient flow and triage.
- Responding to institution emergencies with MLP or physician back up.
- Coordinating the workload/duties of the Licensed Practical/Vocational Nurse (LPN/LVN).
- Screening new arrivals and assessing inmates returning from consultant visits or hospitalizations.
- Providing patient education, etc.

(d) **Licensed Practical/Vocational Nurse (LPN/LVN)**. The LPN/LVN, who is accountable to the RN, will provide healthcare support for other clinical staff. LPN/LVN duties will include but not be limited to:

- Collecting patient information including vital signs and blood pressure checks.
- Providing dressing changes.
- Administering treatments and/or medications.
- Performing EKGs, etc.

(e) **Health Information Technician (HIT)**. The HIT will obtain medical records for the health care providers. Other duties will include:

- Entering SMD data.
- Filing lab/x-ray/consultant reports.
- Scheduling consultant visits, etc.

(f) **Medical Clerical Staff**. Clerical staff will be responsible for:

- Ordering/stocking forms and supplies in the examination and treatment rooms.
- Answering the telephone.
- Locating inmates who do not report for scheduled appointments.
- Clerical support for the PCPT.
- Assisting with SMD entry, entering call-outs, etc.

(2) **After-Hour Coverage.** After-hour, weekend, and holiday coverage will be provided by registered nurses and/or EMTs, where available, based on the institution's hours of in-house health care staff coverage.

An MLP may, under special circumstances, be assigned to evening and weekend coverage at institutions/complexes where the institution's size and complexity warrants.

Local procedures will be established to provide for emergencies including:

- Calls from institution staff requesting an emergency appointment for an inmate during day watch, Monday-Friday. In this situation, typically, triage will be conducted by the team's registered nurse and the inmate's primary MLP would see the inmate if necessary.
- Significant medical emergencies such as trauma, heart attack, asthma attack, etc. will be treated immediately by appropriate team members.

(3) **Vacancies.** As Health Services vacancies occur, each vacancy should be evaluated carefully to determine the best type of provider to hire to implement the PCPT model.

Institutions are encouraged to fill these positions with appropriate Bureau staff through the Priority Placement Program, Merit Promotion Plan, voluntary transfer, Public Health Service (PHS), etc.

Activating institutions will develop a Health Services staffing pattern consistent with the PCPT model.

13. **SPECIAL HOUSING UNITS (SHU)**

All Health Services Units will have procedures and control systems to ensure continuity of medical and psychiatric care and treatment for inmates housed in SHUs. Health care staff will be informed immediately when an inmate is transferred to SHU. Procedures will be determined locally.

Local procedures will include at least the following:

- Protocols to provide for the assessment and review of inmates transferred to SHU.
- A health care provider will make daily rounds during the "lights on" period, except in extenuating circumstances. These rounds will be announced and recorded on the Special Housing Unit Record (BP-A0292).
- A mechanism describing how SHU inmates will notify medical staff of their need for health care.
- Daily rounds to triage urgent requests for care (should be accomplished by the same staff member who conducts the morning pill line in SHU, typically an RN/LPN/LVN).
- Procedures for follow-up care by an MLP or physician. All SHU inmate encounters, including medication refills or dispensing of over-the-counter medications, will be documented in the inmate health record.

The health record should be available when a SHU inmate is examined or treated for all but the most minor of conditions, if possible.

Health care staff will take particular care to monitor any inmate who is a potential suicide risk. See the Program Statement **Suicide Prevention Program**.

14. REFERRAL PROCEDURES BETWEEN HEALTH CARE PROVIDERS

Each institution will develop and maintain a log book (or equivalent computerized tracking system available to all HSU staff) to facilitate referrals between health care providers and the physician. Recommended elements of this log include:

- Date of referral.
- Register number.
- Inmate last name, first name.
- Referring provider.
- Referred to Dr._____.
- Reason for referral.
- Date referral noted by physician, with physician's initials.
- Date inmate to be seen by physician.
- Date seen by physician.

Inmates who are evaluated by an MLP on three separate occasions, without a definitive diagnosis or response to treatment, will be referred to a physician for evaluation.

15. CHRONIC CARE CLINICS

Chronic Care Clinics (CCCs) are a means for inmates with ongoing medical needs to be tracked and seen by a health care provider at clinically appropriate intervals. A physician will see all inmates assigned to a CCC every 12 months, or more often if clinically indicated.

The frequency of CCC follow-up care will be determined based on clinical need and communicated to the inmate's primary MLP, who will provide this care.

The physician will review the health records of all CCC follow-up encounters the MLPs perform.

High risk or medically complex chronic care inmates will be seen more frequently in accordance with good clinical judgment, in addition to or in conjunction with regular visits with their primary provider.

All treatment and management decisions a physician or MLP make will be communicated to the inmate's assigned primary provider for continuity of care.

The CD or staff physician will:

- Initially examine all new arrivals from other institutions that have a CCC assignment, within 14 days of arrival, to establish a treatment plan and follow-up intervals appropriate for the inmate's medical needs.
- Personally examine and approve all additions and deletions of inmates to a CCC.

The CD retains overall professional responsibility for managing CCC inmates. The CD is expected to provide consultation to the MLPs as needed.

Prescribers may order chronic care medications for up to 365 days, except with the limitations outlined in the National Drug Formulary. Inmates chronically taking medications that cannot be prescribed for 365 days will be followed by a physician.

16. **DOCUMENTATION**

The HSA will ensure that a Bureau approved tracking system is maintained and is accessible to all Health Services Staff, to ensure identification and follow-up of patients assigned to CCCs.

Generally, inmates should not be placed in separate clinics to address various conditions (e.g., a diabetic patient with angina and high cholesterol should be seen on only one CCC (primary diagnosis) and all relevant issues addressed at each visit).

In some cases, it is appropriate to assign an inmate to multiple clinics if this allows better tracking for follow-up by outside specialists, e.g. psychiatrists and infectious disease consultants.

CCC visits will be documented on the Chronological Record of Medical Care (SF-600) using the **SOAP** format (see below.)

CCC entries will be preceded by a block stamp identifying the note as "Chronic Care Clinic," or a specific condition such as "Diabetic Clinic" or "Mental Health Clinic."

All Progress Notes must be legible and written in black or dark blue ink.

a. **SOAP Format.** Patient encounters will be documented using the SOAP format:

S-Subjective or Symptomatic data.
O-Objective Data.
A-Assessment.
P-Plan.

Patient education is a required element of the treatment plan. Education may be documented under "P," or may be documented separately ("**SOAPE**").

Patients who complain of pain, will be assessed and treated if necessary.

b. **Administrative Notes.** Administrative notes are notes placed on the SF-600 to document issues important to the inmate's care when the inmate is not seen by the provider at the time of the entry, such as:

- Review of laboratory and radiology results.
- Review of consultant reports.
- CD updates on an inmate's status in the community hospital.
- Medication refills not related to a clinic visit.
- Instances when the inmate is not examined or does not report for a scheduled appointment.

c. **Request for Consultation.** All requests for consultation by an outside consultant or contract health care provider must be in writing on the Consultation Sheet form (SF-513). Sufficient clinical information should be provided at the top of the SF-513, or by attaching copies of documents from the inmate health record, to describe the inmate's complaint or condition, and the information being sought by the referring physician.

The CD, or designee, must review and approve all requests for consultation by a specialist prior to the consultation.

It is expected that a staff physician will have examined most inmates referred to an outside consultant.

All encounters by consultant providers will be documented on the SF-513. Transcribed consultation reports will be filed with the SF-513.

Contract consultants who evaluate inmates within the institution will not document on the Progress Notes.

All consultation reports will be reviewed, co-signed and dated by the Clinical Director or staff physician.

Bureau physicians are not obligated to follow all consultant recommendations. If a consultant makes a recommendation which is outside Bureau policy or scope of services, the CD will

document thoroughly the reasons the consultant's recommendations are not followed, based on input from the staff physician.

17. **TRIAGE/ACCESS TO CARE**

Triage is defined as the classification of patients according to priority of need for examination and/or treatment. Triage allows truly urgent conditions to be addressed adequately on the same day, while also allowing more routine conditions or concerns to be addressed at a scheduled appointment. During triage the following will occur:

- The inmate will provide a brief history.
- Vital signs will be taken, if indicated.
- An appointment will be scheduled with the appropriate provider within a time frame appropriate for the inmate's condition and medical needs.
- If no follow-up appointment is warranted, the inmate will be advised of other options (e.g. obtaining over-the-counter medications from the Commissary, submitting an Inmate Request to Staff (BP-A0148), etc.

An Inmate Request for Triage Services will be completed for each inmate. The form is to be pre-printed onto an SF-600. These forms will be filed in Section 1 of the inmate health record.

If no appointment is scheduled as a result of triage, this will be noted on the triage form and will be turned in to the Health Information Department for filing.

a. **Appointments.** Virtually all clinical services provided to the inmates will be by appointment, scheduled several days to weeks in advance through a request from the inmate or follow-up appointments determined by the providers.

Institutions not yet implementing the full PCPT model will use the triage system described above.

Inmates may request clinical services on a daily basis by completing the Inmate Request for Triage Services form. Health Services staff will triage and prioritize the requests and schedule appointments based on need.

Physicians and other health care providers will be available five days per week to provide clinical services.

Urgent Care services (injuries, chest pain, asthma attacks) will be available at all times, either through on-site providers or community emergency services.

b. **Examination Areas**. Staff will see inmates individually in a private examination area. Other inmates will not be present, except in emergencies or other unusual circumstances (i.e., as a translator when staff interpreters are not available).

Ordinarily, the examiner will have the inmate's health record during all inmate visits. If the health record is not available for a routine examination, the inmate should be rescheduled. Staff will document the reason the health record was not available.

The examining room will have adequate space (minimum of 100 sq. ft.), running water, and provision for both the examiner and inmate to be seated.

There will be adequate desk space so that the examiner may make notes in the inmate health record.

Necessary forms, equipment, and supplies, including an examining table will be available.

A sharps bio-hazard disposal container, mounted to the wall if possible, will be located in all rooms where needles and syringes are used.

Appropriately labeled bio-hazardous waste containers will be available.

Examination rooms will be cleaned regularly including the disinfection of examination tables and contaminated surfaces. Inmate orderlies may perform this task.

Between each patient, the examination table must either be wiped down with a disinfectant or the table paper must be changed.

When patient encounters are conducted in a satellite area (segregation, special custody units, industry locations, camps, units with difficult egress, etc.), adequate space and equipment will be available, consistent with the requirements above.

The **SOAP** label may be used to document a patient encounter in Special Housing/detention units in lieu of the inmate's health record. This label is then affixed to the SF-600.

c. **Privacy.** Staff will provide inmates the opportunity to discuss their medical complaints without other inmates being present.

18. **INTAKE SCREENING**

a. **Newly Incarcerated Inmates.** Health Services clinical staff will conduct an initial assessment of each newly committed inmate upon his/her arrival at an institution. This screening is to determine:

- Urgent medical, dental, or mental health care needs.
- Signs of acute drug or alcohol intoxication or symptoms of withdrawal.
- Restrictions on temporary work assignments.
- Freedom from contagious infectious disease.

Inmates with perceived immediate medical/dental/mental health needs will be referred to the appropriate health care staff for evaluation.

b. **Bureau Intra-system Transfers**. The BEMR Exit Summary for Inmate Intra-system Transfer will be reviewed and annotated appropriately at each receiving institution, including the designated institution.

It is prohibited to transfer inmates between Bureau institutions, (including all holdover status inmates, i.e., DEA, U.S. Marshals Service, Bureau of Immigration and Customs Enforcement [formerly INS], FBI, etc.), who have not been screened for TB. This prohibition does not apply to court-related activities or inmates being transferred on writ (to non-Bureau institutions).

It is the HSA's responsibility to ensure health services staff completing the BEMR Exit Summary for Inmate Intra-system Transfer have documented TB screening results and that the inmate is cleared for transfer prior to electronically signing the form.

Transporting officials will not accept any inmate for transfer unless either PPD or chest x-ray results are completed and satisfactory for transfer, as noted on the BEMR Exit Summary for Inmate Intra-system Transfer.

19. **PHYSICAL EXAMINATIONS**

a. **Short-Term Examination.** For individuals in predictably short-term custody (FDCs/MCCs/ MDCs/Jails), an initial screening physical examination to determine medical needs will be done **within 14 days of admission** on the appropriate physical examination form.

However, TB screening must be initiated within two working days of incarceration. (See the Program Statement **Infectious Disease Management**.)

Initial screening physical examinations include, but are not limited to, the following components:

(1) **Medical and Mental Health.** Complete the history and screening physical examination form(s).

Inmates showing signs of acute drug or alcohol intoxication or withdrawal symptoms will be managed in accordance with the institution's local procedure for detoxification of chemically dependent inmates.

Staff will obtain a detailed history of substance use and conduct an examination.

Health Services staff will complete a written referral to the institution Chief Psychologist and Clinical Director for any inmate showing evidence of substance dependence/abuse.

(2) **Dental.** Complete the dental intake screening form(s) in accordance with the Program Statement **Dental Services**.

(3) **Ordering of appropriate laboratory and diagnostic tests,** if clinically indicated. Examples include hepatitis screening, sickle cell screening (hemoglobin electrophoresis is recommended over Sickledex), sexually transmitted disease (STD) testing, chest x-ray, EKG. (Refer to the Program Statement **Infectious Disease Management** for HIV testing.)

The physical examination is considered complete when the above three steps are completed. The CD will review and sign the completed physical examination form.

Clinically indicated laboratory test results do not need to be received prior to signing the physical examination form.

Any abnormal laboratory results generated as part of the physical exam must be documented in the progress notes.

The inmate must be counseled regarding any necessary follow-up treatment or testing within a clinically appropriate time frame.

Intra-system transfers do not need a second complete initial physical examination as long as one has been completed for this period of confinement. Inmates who present any new medical problems will be assessed appropriately.

b. **Long-Term Examination.** For individuals in predictably long-term incarceration (sentenced/designated), an initial complete physical examination to determine medical needs will be done within 14 days of admission on the appropriate examination forms.

However, TB screening must be initiated within two working days of incarceration. (See the Program Statement **Infectious Disease Management**.)

The initial complete physical examination includes, but is not limited to, the following components:

(1) **Medical and Mental Health.** Complete the history and physical examination form(s).

Inmates showing signs of acute drug/alcohol intoxication or withdrawal symptoms will be managed in accordance with the institution's local procedure for detoxification of chemically dependent inmates.

Staff will obtain a detailed history of substance use and conduct an examination.

Health Services staff will complete a written referral to the institution Chief Psychologist and Clinical Director for any inmate showing evidence of substance dependence/abuse.

(2) **Dental.** Complete the dental examination forms in accordance with the Program Statement **Dental Services**.

(3) **Ordering of appropriate laboratory and diagnostic tests,** if clinically indicated. Examples include hepatitis screening, sickle cell screening (hemoglobin electrophoresis), STD testing, chest x-ray, EKG, age-appropriate preventive health examinations. (Refer to the Program Statement **Infectious Disease Management** for HIV testing.)

The physical examination is considered complete when the above three steps are completed. The CD will review and sign the complete physical examination form.

Clinically indicated laboratory test results do not need to be received prior to signing the physical examination form.

Any abnormal laboratory results generated as part of the physical exam must be documented in the progress notes.

The inmate must be counseled regarding any necessary follow-up treatment or testing within a time frame which is clinically appropriate.

The long-term examination policy applies to all Bureau institutions, except as noted above under the short-term physical examination section. Unless clinically indicated, Health Services staff does not need to complete a new physical examination on an inmate who has had one documented, provided the inmate has been in continuous custody.

A complete physical examination will be required for inmates who are out of BOP custody for more than 30 days (e.g., furlough, writ, or a halfway house failure).

For an inmate transferred from another Bureau institution, staff need not conduct a second complete initial physical assessment if the inmate does not present any new medical problems and has already had a complete health assessment for this period of confinement.

c. **Periodic Health Examinations.** The Medical Director will ensure the availability of age-specific preventive health examinations (e.g., cancer screening) for the inmate population.

Information regarding these examinations will be made available through the A&O process, posted information in the HSU, and individual patient education associated with clinical encounters.

d. **Food Handlers' Examinations**. Inmates will not be assigned to Food Service work details until they are cleared by Health Services. If a complete history and physical examination has been documented but is more than one year old, a brief in-person examination will be conducted to update the inmate's history and screen for the conditions listed below.

This encounter will be documented on the SF-600 and the date of clearance for Food Service will be updated on SENTRY.

Annual Food Handler examinations will not be required, however, upon orientation to Food Service, Food Service staff will provide inmates with an information sheet instructing them to report to their detail supervisor should they display symptoms of any of the following:

- Acute or chronic inflammatory conditions of the respiratory system.
- Acute or chronic skin conditions.

- Acute or chronic intestinal infections (vomiting or diarrhea).
- A communicable disease.

Note: HIV, HBV, or HCV infection or latent TB (positive PPD without active tuberculosis) pose no risk of food borne transmission.

Inmates with HIV, HBV or HCV infection or latent TB are not precluded from working in Food Service based on this status alone.

The primary care provider will determine the inmate's suitability for Food Service.

Inmates will sign and date a copy of the information provided to them and this copy will be maintained on file in the Food Services Department.

When an inmate notifies the detail supervisor of the presence of any of the above signs or symptoms, he/she will be referred to the HSU for re-examination.

Inmates will be monitored daily for health and cleanliness by the Food Services Administrator, or designee.

Inmates exhibiting signs of infected cuts or boils will be referred to the HSU for re-examination.

20. **FEMALE HEALTH CARE**

a. **Requirements for Routine Physical Examinations of Female Inmates.** In addition to the elements described in Section 19 for complete physical examinations (long-term), the following elements apply to routine physical examinations of female inmates:

- A gynecological and obstetrical history, including sexual activity and any recent rape history.
- Order a pregnancy test for females of childbearing age (urine or serum) and other tests as clinically indicated.
- Conduct a breast and pelvic examination. A female staff member will be present when a male provider performs breast and pelvic examinations (except in emergency situations when a female staff member is not available).
- Annual breast examinations will be made available to inmates upon request.
- Self-examination instructions will be given to all females at the time of the breast examination.
- Offer Pap smear; collect chlamydia, gonorrhea and/or other endo-cervical cultures from vaginal and/or anal orifices when clinically indicated.

The Medical Director will ensure the availability of age- specific preventive health examinations (e.g., cervical, breast) for the female inmate population.

b. **Mammography.** Mammography will be used as a diagnostic tool.

- **Sentenced Status**. Perform baseline mammography for sentenced females aged 50-74 years old unless a younger female is assessed to have a high risk for developing breast cancer.
- **Pre-sentenced or Holdover Status**. Perform baseline mammography for pre-sentenced or holdover female inmates aged 50-74 years old who have been continuously housed at the institution for 12 months. When the 12-month interval is reached, baseline mammography should be scheduled within 30 days and completed before the end of the second year of being continuously housed at the institution. Females younger than 50 years of age in pretrial or holdover status for 90 days, and who have identified risk factors for breast cancer, should be scheduled for baseline mammography.

If the inmate refuses mammographic screening, a Medical Treatment Refusal form (BP-A0358) will be signed.

When a breast mastectomy is performed in the treatment of cancer, breast reconstruction is considered Medically Necessary, Not Emergent (Level 2).

Chest x-rays are only required during the initial physical exam if clinically indicated.

Female inmates of child bearing age will be questioned as to the possibility of being pregnant prior to taking any x-rays. This information will be documented on the Radiologic Consultation Request/Report form (BP-A0622).

c. **Prescription Birth Control.** Upon request, inmates will be provided information pertaining to appropriate methods for birth control. Ordinarily, the medical indication and appropriateness of prescribing birth control medication in a correctional environment is limited to:

- Hormonal manipulation for menstrual irregularity.
- Hormonal replacement therapy in post-menopausal women as clinically indicated.

Prior approval of the Bureau's Medical Director is required if a clinician believes birth control is medically appropriate for a condition other than those noted above.

Sterilization may not be provided as a form of birth control.

Intrauterine devices (IUDs), or other implanted contraceptive devices, will not be made available to inmates. Inmates entering the Bureau with these devices in place will be advised of possible complications associated with continued use, with documentation in the inmate health record. These devices may be removed upon the inmate's request.

d. **Pregnancy.** When pregnancy is confirmed, the inmate will be referred to a physician within 14 days for an initial examination and management of the pregnancy.

The HSA will notify the inmate's unit manager promptly when pregnancy is confirmed. (Refer to the Program Statement **Birth Control, Pregnancy, Child Placement and Abortion**.)

All pregnant inmates will be offered HIV antibody testing with documentation on the SF-600.

A prenatal vitamin should be prescribed to all pregnant inmates unless contraindicated.

e. **Childbirth.** Prior to an inmate giving birth, the Warden will ensure the person or agency taking custody of the child is asked to take responsibility for all medical expenses from the time of delivery (including the first three days after birth).

Unit management, or a social worker if available, will obtain a signed statement of responsibility from whomever receives custody of the child.

This statement of responsibility will clearly indicate the signing party accepts financial responsibility for all medical expenses for the child.

A copy of the signed statement of responsibility will be sent to the HSA for placement in the outside hospitalization file and another copy sent to the Controller.

Administrative discretion to pay for the immediate postnatal care of the child born to a female inmate is authorized when no other resource can be compelled to pay. Legislation is not required to authorize payment for the child's immediate medical needs. It is reasonable for the Bureau to provide for the child's medical expenses:

- For the first three days following routine vaginal delivery.
- Up to seven days following delivery by Cesarean section.

The Regional Director may extend this an additional seven days for extenuating circumstances on a case-by-case basis. Any further extension will require approval by the Medical Director.

f. **Pregnancy Statistic Reporting Requirements.** Institutions will report the name, register number, and expected due date of all pregnant females to the Chief of Health Information Management, Health Services Division, Central Office, via BOPNet GroupWise.

All live births will be reported to the Chief of Health Information Management.

A follow-up report is required for all pregnancies that end in other than a live birth (i.e., abortion, miscarriage, premature birth, stillbirth).

21. INMATE IMMUNIZATIONS

Refer to the Program Statement **Infectious Disease Management**.

Staff will notify inmates of the availability of immunizations through A&O and posted information in the HSU.

Health Services staff will maintain a standard immunization record in each inmate health record. Upon request, the Health Information Department will provide inmates with a copy of their immunization records following their release.

22. SURGICAL SERVICES

Health Services staff will ensure that Consent for Anesthesia forms (SF-522) are completed for:

- All ambulatory-type surgical procedures.
- Local anesthesia for diagnostic and therapeutic purposes.
- Joint injections.
- Flexible endoscopy.

Consent forms are strongly recommended for laceration repair (suturing), especially on the face, or when fascia or tendon sheaths require closure.

All institutions will have written surgical policies and procedures in accordance with Joint Commission and safety standards.

23. SURGICAL PATHOLOGY

Histology/cytology specimens removed during a surgical procedure will be sent to an approved pathologist for examination. All specimens will be packaged in preservative as indicated by type of specimen and local procedures. All specimens will be labeled with the following:

- Inmate name.
- Register number.
- Date of collection.
- Source of specimen.

Refer to the Program Statement **Dental Services** for information regarding dental pathology.

24. SERIOUS ILLNESS AND DEATH PROCEDURES

An Institution Supplement will be developed to incorporate specific information covered in the categories listed below, including:

- Serious Illness and Death Procedures, including who may pronounce death according to state law, and notification of the coroner or medical examiner.
- Inmate Advance Directives ("Living Wills").
- Request for consideration of reduction in sentence ("compassionate release").
- "Do Not Resuscitate" (DNR) Orders.

For further information refer to the Program Statement **Escapes/Deaths Notifications**.

When an inmate's medical condition becomes life-threatening and death may be imminent, the principles and procedures listed below will be followed.

The Bureau remains committed to the principle of preserving and extending life. A seriously ill or dying inmate should be provided care consistent with this goal.

When an inmate is in a community hospital, the Bureau retains authority regarding administrative decisions (visitors, movement of the inmate, limits on medical services the Bureau will authorize, etc.) and the hospital retains authority for professional medical decisions (drug regimen, laboratory tests, x-rays, treatment performance, etc.).

As long as the treatment conducted by the hospital and agreed to by the inmate or family does not exceed the scope of medical services the Bureau provides, normally the treatment will be permitted.

In most cases, the inmate will be in a local hospital and the hospital will have procedures complying with State law regarding the involvement of next of kin.

The hospital will be permitted to follow its established bylaws concerning seriously ill or dying inmates, e.g. initiating DNR orders and discontinuing artificial life support.

The Bureau will be kept informed of the treatment the inmate is receiving, but medical staff of the hospital will retain the authority for decisions concerning treatment.

a. **Serious Illness.** An inmate's serious illness is of immediate concern to the inmate's family; the institution will notify the next of kin promptly. If approved by the Warden, the immediate family member (next of kin) will be made aware of the medical condition and the limitations placed on visiting.

While the Bureau will continue to control conditions under which a family member may visit, consideration will be given to providing the maximum opportunity for visitation. (Refer to Program Statement **Inmate Visiting**.)

As soon as possible, the HSU will notify the Warden and Chaplain by phone or in person of the inmate's condition, and the Warden, or designee, will arrange to notify the family. Subsequently, the Warden will be notified of the illness by confirming memorandum from a medical staff member.

The memorandum will describe the illness briefly and provide a prognosis, if possible. A copy of the memorandum will be sent to the Chaplain. If a pretrial inmate becomes seriously ill, requires major surgery, or dies, the Warden, or designee, will also notify the committing Court and the U.S. Attorney's Office. (Refer to the Program Statement **Escapes/Deaths Notifications**.)

When inmates are suitable candidates for early release through a Reduction in Sentence (often called compassionate release) and the inmate and family desire such an arrangement, the institution will expedite processing of the request. (Refer to the Program Statement **Compassionate Release; Procedures for Implementation of 18 U.S.C. §§ 3582(c)(1)(A) & 4205(g)**).

If an inmate is a suitable candidate for medical furlough, refer to the Program Statement **Furloughs**.

In case of death, the Warden or the Warden's representative will notify the family of the deceased in the same manner as serious illness notification.

b. **Autopsies.** Inmates who expire as a result of a known terminal disease do not routinely require an autopsy. Refer to the Program Statement **Autopsies**, and the Autopsy Authorization form (BP-A0797).

Before initiating an autopsy or embalming, a determination of the inmate's religious preference will be made. Religions, including Judaism and Islam, forbid embalming. Additionally, there are other religion specific requirements involving autopsies and embalming.

It is critical the institution's religious services department head be consulted prior to final authorization for an autopsy or embalming.

Each institution will develop procedures describing when to contact the local coroner or medical examiner regarding such issues as:

- Performing an autopsy.
- Who will perform the autopsy.
- Obtaining State-approved death certificates.
- Local transportation of the body.

State laws regarding these issues vary greatly and when legal questions arise, the Regional Counsel should be contacted. State law provisions and guidelines on when to contact the coroner or medical examiner will be incorporated into an Institution Supplement and a copy forwarded to the Regional Counsel.

c. **Advance Directives and "Do Not Resuscitate (DNR) Orders."** Increasingly, inmate and health care providers are confronted with difficult and sensitive decisions regarding health care, including the decision to have extraordinary means of care and life support withheld or withdrawn in cases of a terminal condition or irreversible illness. This section provides guidance on creating and implementing these advance directives.

Inmates may direct, in advance, to withhold or withdraw certain medical treatments when recovery or cure is not possible.

Inmates may appoint, in advance, proxy decision makers who will make critical health care decisions for them should they become incapacitated and unable to make such decisions for themselves.

The Bureau's withholding or withdrawal of resuscitative or life-support services pursuant to an Advance Directive or DNR order, is consistent with sound medical practice and is not associated with assisting suicide, voluntary euthanasia, or expediting the inmate's death.

The patient's right to refuse medical treatment is not absolute and, in all cases, will be weighed against legitimate governmental interests, including the security and orderly operation of correctional institutions.

d. **Institution Supplement**. To facilitate the creation and implementation of advance directives and DNR orders, each institution will develop an Institution Supplement according to this Program Statement.

The Warden, Regional Director, and Medical Director must review and approve Institution Supplements. Supplements will be negotiated locally prior to implementation.

Regional and local Bureau legal staff should be consulted in drafting Institution Supplements under this section.

(1) **Advance Directives.** Each Institution Supplement addressing advance directives must:

- Provide information which complies with the law of the state where the institution is located. A copy of the relevant state's law should be an attachment to each Institution Supplement.
- Include a sample standard form for inmate use if available from the relevant state statutes on advance directives.
- Include instructions for inmates wishing to execute advance directives before, or after, the onset of a seriously debilitating or terminal illness, including the option of retaining private legal counsel at the inmate's expense for assistance.
- Require filing inmates' executed advance directives in the inmate health record.

(2) **DNR Orders**. Each Institution Supplement addressing DNR orders must:

- Provide information which complies with the law of the state where the institution is located. A copy of the relevant state's statutes should be an attachment to the Institution Supplement, if they exist. This includes state laws addressing non-liability of healthcare practitioners who implement advance directives in good faith.
- Instruct that, in all cases, decisions a competent inmate expressed supersede any previously executed advance directive to the contrary.
- State that DNR orders **will never** be invoked while an inmate is housed at a general population institution. Emergency resuscitative measures must always be performed on an inmate who suffers cardiopulmonary arrest at a general population institution. Advance

directives may be implemented only at community health care facilities or MRCs, while the inmate is under a physician's direct care and treatment.
- Instruct that validly executed advance directives will be honored by entering DNR orders as appropriate at MRCs.
- Instruct that validly executed advance directives will be honored by community healthcare facilities according to their by-laws and relevant state and local laws.

The Institution Supplement will also include the following procedures for implementing DNRs:

(a) All DNR orders written for inmates in MRCs must be approved by the Clinical Director (CD) or acting CD.

(b) A valid DNR order must be documented in the inmate's health record, including:

- Standard terminology (i.e., "Do Not Resuscitate" or "DNR"), legibly written, signed by the ordering physician, and placed on the front of the record and inpatient chart, as well as the doctor's order sheet.
- The inmate's diagnosis.
- The inmate's prognosis.
- The inmate's written advance directive, or other authorized expression of healthcare decisions, as well as available documentation of the inmate's informed consent, when available.
- Documentation regarding the inmate's competence, when the decision to enter a DNR is based on his/her expressed request.
- The wishes of immediate family member(s), if available.
- Decisions and recommendations of other medical staff or consultants, with documentation of names.

(c) DNR orders are subject to regular review by the ordering physician.

(d) Inmates with DNRs in their health record remain entitled to maximal therapeutic efforts short of resuscitation.

(e) Bureau physicians at MRCs may not be compelled to sign a DNR based on their clinical judgments, or ethical or religious convictions.

To protect the interests of both the inmate and the Government, the Government may, in some cases, seek judicial or administrative review of the declaration in an Advance Directive.

When the inmate is unconscious or otherwise unable or incompetent to participate in the decision, every reasonable effort will be undertaken to obtain written concurrence of one or several immediate family members. The attending physician must document these efforts in the health record.

A DNR order may be the result of the attending physician's decision that the inmate is in a terminal condition and further medical treatment is futile. When a DNR order conflict exists between the primary care physician and the inmate or the inmate's proxy decision maker, a referral to the MRC ethics committee will be made.

Should the committee be unable to resolve the conflict, the issue will be referred to the Bureau's Medical Director for final determination.

25. **BODY SEARCHES FOR CONTRABAND**

Under no circumstances will laxatives, enemas, or emetics (any form) be used to induce a bowel movement or vomiting to help remove contraband. The only exception is, if a medical condition requires prescribing laxatives, enemas, or emetics, the Clinical Director must order this medication weighing the potential danger to the inmate if contraband is present.

When a Warden authorizes a cavity search as stated in the Program Statement **Searches of Housing Units, Inmates, and Inmate Work Areas**, qualified health care personnel will perform the cavity search.

The use of a fluoroscope, major instrument (including anoscope or vaginal speculum), urinary catheter, or surgical intrusion will only be authorized for medical reasons, with the inmate's consent.

The only exception is if an x-ray examination is determined necessary for the safety and security of the institution, the **Warden, with the Regional Director's approval,** may authorize the physician to order a non-repetitive x-ray examination to determine if concealed contraband is present in or on the inmate. (Refer to the Program Statement **Searches of Housing Units, Inmates, and Inmate Work Areas** for further direction.)

26. **SPECIAL DIETS**

Unless clinically indicated as part of the treatment regimen, medical staff will not order special food items. When a special diet is required to supplement a medical regimen, the Program Statement **Food Service Manual** will be consulted.

Special diets will be prescribed only by the CD, staff physician, staff psychiatrist, or staff dentist.

MLPs at MRCs may prescribe a special diet, but it must be countersigned by the primary physician.

Weight loss diet programs will not be implemented without the physician's approval.

Documenting patient education regarding diet recommendations in the health record is the responsibility of the prescriber and dietitian.

If there is no full-time dietitian, it is highly recommended that MRCs contract for a consultant dietitian who will provide counseling services and patient education.

27. **EYE CARE**

a. **Eyeglasses**. The Bureau will furnish prescription eyeglasses to any inmate requiring them, as documented through a professional prescription. Federal Prison Industries, FCI Butner, NC, is the only approved vendor at Government expense.

Inmates may purchase reading glasses at commissaries which stock them.

The HSA, in consultation with the CD and consultant optometrist, may elect to stock a supply of reading glasses in various magnifications which the optometrist may dispense when the inmate only requires magnification.

The HSA may purchase glasses through usual supply procedures.

Inmates may retain their eyeglasses at admission. All such glasses are subject to inspection for contraband. Inmates may retain this pair of eyeglasses until the lenses or frames must be changed or repaired, at which point the Bureau will furnish replacement eyeglasses through Federal Prison Industries.

b. **Contact Lenses**. Contact lenses will only be prescribed when, in the clinical judgment of a Bureau or contract optometrist or ophthalmologist, with the concurrence of the CD and HSA, an eye-refractive error is best treated with the prescription of contact lenses. Generally these cases are limited to the following:

- Diagnosis of keratoconus.
- Certain inmates with artificial lens implants.

HSU staff will evaluate sentenced inmates arriving at an institution with contact lenses and refer them to a Bureau or contract optometrist or ophthalmologist to determine whether they may retain the lenses. Unless contact lenses are medically necessary, HSU staff will inform the inmate that an appointment will be made with the institution's optometrist for an eyeglass prescription.

The only exception to the above is non-sentenced inmates who are housed in BOP institutions.

Once the glasses are received, the contact lenses must be returned to the inmate's personal property or mailed home.

HSAs will ensure adequate contact lens supplies are available for inmates authorized contact lenses (those who must wear contacts as opposed to glasses), non-sentenced inmates, or those awaiting eyeglasses.

28. **HEARING CONSERVATION PROGRAM**

Whenever individual occupational noise exposure equals or exceeds the eight-hour time weighted average (TWA) sound level of 85 decibels (and above) measured on the "A" scale (dBA), the institution will initiate a hearing conservation program. At a minimum, the program will meet the requirements of paragraphs (c) through (o) of 29 CFR Part 1910.95. Major elements include:

- Monitoring areas where noise levels are expected to equal or exceed an eight hour time weighted average of 85 dBA.
- Notification of inmates occupationally exposed to a TWA at or above 85 dBA.
- Audiometric testing for those exposed.
- A training program.

a. **Initial Survey.** The Safety Manager will arrange for an initial survey of the institution to identify work areas where inmates are subjected to noise exposure of 85 dBA TWA or higher. The Safety Manager will designate any work assignment where an inmate is exposed to a TWA threshold that meets or exceeds 85 dBA as a high noise job.

The Safety Manager will notify the HSA and the affected department head of each high-noise job designation. Each inmate assigned to a high-noise job will:

- Be fitted with hearing protection.
- Be required to wear the hearing protection device while working.

- Be trained in accordance with 29 CFR 1910.95.

The Safety Manager will be responsible for ensuring hearing protection fitting and training. The department head of the high noise area is responsible for ensuring that hearing protection is worn in the work area.

The department head will notify the HSA when an inmate is assigned to a high-noise area. The HSA or designee, will obtain a baseline audiometric test as soon as possible, but no later than six months after that job assignment, and the HSA will notify the department head of the date when testing is performed. Audiometric tests will be made at the 500, 1,000, 2,000, 3,000, 4,000, 6,000, and 8,000 Hertz (hz) frequencies.

When mobile test vans are used to meet the audiometric testing obligation, the HSA will obtain the audiometric test as soon as possible, but no later than one year after the job assignment.

Detectable hearing loss at initial testing does not preclude the inmate's assignment to a high-noise area, provided hearing protection is worn.

Inmates who are deaf may be allowed to work in high- noise areas, provided an assessment of safety factors is performed to determine if the work place is otherwise safe and appropriate, with or without reasonable accommodations.

Inmates who are intra-system transfers, and who are assigned to a high-noise area in their new institution, will use the baseline audiogram performed at the sending institution, if available.

b. **Annual Retesting.** Each inmate assigned to a high-noise area must receive audiometric retesting at least annually. It is the department head's responsibility to notify the HSA of each inmate needing annual testing.

Upon retesting, any inmate found to have a standard threshold change or shift of 10 dB or more as compared to a baseline average over 2,000, 3,000, or 4,000 hz frequencies must be retested within 30 days.

The results of the retest will be considered the annual audiometric test.

It is important to factor in age-related hearing loss as described in 29 CFR 1910.95, Appendix F, when administering an annual retest.

Unless the Clinical Director determines that a standard threshold shift of greater than 10 dB is not work-related or aggravated by occupational noise exposure, the Safety Manager will ensure that the inmate is:

- Refitted with hearing protection.
- Trained in its use and care.
- Required to wear the hearing protective device.

The HSA will notify the Safety Manager of each inmate who must be refitted and retrained.

c. **Audiometric Testing.** Audiometric tests will be performed by a licensed or certified audiologist, otolaryngologist, or other physician, or by a technician who is certified by the Council of Accreditation in Occupational Hearing Conservation. Staff who have demonstrated skill and knowledge satisfactorily, as determined by a licensed or certified audiologist, otolaryngologist, or other physician, may also perform audiometric testing.

Skill and knowledge must be demonstrated in:

- Administering audiometric examinations.
- Obtaining valid audiograms.
- Properly using, maintaining, and checking calibration and proper functioning of the audiometers being used.

A technician who operates microprocessor audiometers does not need to be certified. A technician who performs audiometric tests must be responsible to an audiologist, otolaryngologist, or physician.

Audiometric tests will be conducted with audiometers that meet the specifications of the American National Standard Specification for Audiometers, S3.6-1969.

If used, pulse-toned and self-recording audiometers will meet the requirements specified in 29 CFR 1910.95, Appendix C, “Audiometric Measuring Instruments.”

Audiometric calibrations will be performed in accordance with 29 CFR 1910.95 (h)(5).

Record keeping will be performed and maintained in accordance with 29 CFR 1910.95 (m).

29. DEAFNESS AND HEARING AIDS

Hearing aids can be justified only by bona fide clinical indication. The CD, in consultation with an audiologist or otolaryngologist, will determine if a hearing aid is medically necessary.

HSAs will ensure that batteries are available for inmates with hearing aids.

If an inmate brings a personal hearing aid into the institution, after verification, he/she will be allowed to keep it. However, the inmate may not purchase a personal hearing aid once committed to an institution.

30. INMATES WITH GENDER IDENTITY DISORDER

Inmates with a possible diagnosis of Gender Identity Disorder (GID), including inmates who assert they have GID, will receive thorough medical and mental health evaluations from medical professionals with basic competence in the assessment of the DSM-IV/ICD-10 sexual disorders and who have participated in BOP's GID training, including the review of all available community health records. The evaluation will include an assessment of the inmate's treatment and life experiences prior to incarceration as well as experiences during incarceration (including hormone therapy, completed or in-process surgical interventions, real life experience consistent with the inmate's gender identity, private expressions that conform to the preferred gender, and counseling).

If a diagnosis of GID is reached, a proposed treatment plan will be developed which promotes the physical and mental stability of the patient. The development of the treatment plan is not solely dependent on services provided or the inmate's life experiences prior to incarceration. The treatment plan may include elements or services that were, or were not, provided prior to incarceration, including, but not limited to: those elements of the real life experience consistent with the prison environment, hormone therapy, and counseling. Treatment plans will be reviewed regularly and updated as necessary.

Current, accepted standards of care will be used as a reference for developing the treatment plan. All appropriate treatment options prescribed for inmates with GID in currently accepted standards of care will be taken into consideration during evaluation by the appropriate medical and mental health care staff. Each treatment plan or denial of treatment must be reviewed by the Medical Director or BOP Chief Psychiatrist. Hormone therapy must be requested through the non-formulary review process, and approved by the Medical Director and /or Chief Psychiatrist. Consultation with the Chief of Psychology prior to such approval may be appropriate in some cases.

In summary, inmates in the custody of the Bureau with a possible diagnosis of GID will receive a current individualized assessment and evaluation. Treatment options will not be precluded solely due to level of services received, or lack of services, prior to incarceration.

31. STERILIZATION

Inmates will not be sterilized, except for bona fide medical indications (e.g. as the result of surgical treatment for cancer of the reproductive organs).

32. DIALYSIS

Inmates with renal disease requiring dialysis (including peritoneal dialysis) will be referred to the Medical Designator for transfer to an MRC or other institution capable of providing dialysis.

A dialysis "re-use" program is permitted.

33. SEXUALLY TRANSMITTED DISEASES

Refer to the Program Statement **Infectious Disease Management**.

34. STANDARD PROCEDURES FOR DETERMINING ALCOHOL INTOXICATION

Staff may be asked to determine whether an inmate is intoxicated. Two procedures are used most often to determine alcohol intoxication.

The Captain, or designee, may administer a breathalyzer test to determine the presence of alcohol. Use of a breathalyzer will remain a non-medical function.

Medical staff may be asked to obtain a blood sample to determine alcohol content.

Usually, blood alcohol testing would be reserved for situations when this information is needed as part of a criminal investigation, or when specifically requested by the Warden. Then, medical staff will:

- Draw blood and forward it to an approved laboratory for testing.
- Complete all chain-of-custody documentation in accordance with the request for this examination.

The inmate's consent is required before blood is drawn, except in medical emergencies when the patient is unable to consent.

35. **DETOXIFICATION**

The CD will establish local protocols for evaluating and treating inmates who require detoxification from mood and mind altering substances such as alcohol, opiates, hypnotics, sedatives, etc. Based on specific guidance from the Medical Director, these detoxification protocols will be implemented based on a physician's order.

Treatment and supportive measures will permit withdrawal with minimal physiological discomfort.

Methadone Detoxification. MCCs, MDCs, FDCs, MRCs, the FTC, and jail units with a methadone detoxification mission, will provide methadone detoxification if clinically indicated. These missions will be determined by the Medical Director.

These institutions must have a current methadone license.

This program requires special registration through the Substance Abuse and Mental Health Services Administration (SAMHSA)

If an institution has a methadone detoxification program, the institution Chief Pharmacist will complete and maintain registration for a methadone program.

Waivers to this requirement must be requested in writing to the Medical Director. The request must detail a specific plan with a community-based program which can readily provide methadone detoxification.

Institutions which could conceivably house pregnant inmates must have a contingency in place for **methadone maintenance**. Ordinarily, pregnant inmates should not be detoxified from opiates until after delivery.

Refer to the Program Statement **Pharmacy Services** for additional information regarding methadone administration.

36. VITAMINS AND NUTRITIONAL SUPPLEMENTS

Inmates will be referred to the commissary to purchase vitamins when their use is for general prevention or health maintenance or for conditions when their use has been promoted but not scientifically proven (e.g. Peyronie's disease, macular degeneration.)

Each multiple vitamin tablet may not contain more than 150% of the Recommended Daily Allowance (RDA) of each vitamin and mineral.

Particular attention should be given to limiting excessive intake of the fat-soluble vitamins (A, D, E, and K.)

Vitamin C tablets may not exceed 500 mg per tablet.

Vitamins which may be purchased from the commissary are listed in the Program Statement **Trust Fund/Deposit Fund Manual**.

When a vitamin supplement is clinically indicated as part of a treatment regimen, the vitamin will be considered medication and will be supplied by the HSU, subject to restrictions in the National Drug Formulary.

Health Services staff will not prescribe, nor will the commissary sell, nutritional supplements such as glucosamine/chondroitin, fish oil, herbal preparations, and other non-Food and Drug Administration (FDA) approved substances.

37. AUTOLOGOUS BLOOD BANKING

The CD will determine when autologous blood collection is medically necessary (e.g. the inmate has an extremely rare blood type, surgery will predictably require transfusion, such that autologous blood banking may be performed).

The CD may authorize autologous blood collection.

Surgical consultants may not require the Bureau to authorize autologous blood banking for an inmate prior to surgery.

38. ORGAN DONATION BY INMATES

These procedures apply to inmates currently incarcerated in the Bureau, not to posthumous donations:

Organ donation is only permitted when the recipient is a member of the inmate donor's immediate family (parents, siblings, and biological children.)

Hospitalizations or fees involved will not be at the Government's expense including all costs associated with guarding the inmate at off-site facilities. This includes the U.S. Marshals Service.

The inmate must sign a statement indicating the desire to donate an organ to a specific relative. The consent must state the following:

- The inmate understands the possible dangers of the operation.
- The inmate agrees of his/her own free will.
- The Government will not be held responsible for any complications or financial responsibilities.

When an inmate is appropriately designated as community custody, the inmate may request consideration for a medical furlough, in accordance with the Program Statement on Inmate Furloughs.

The local institution will coordinate procedures such as transportation, custody, classification, compatibility determinations, evaluation, hospitalization, furlough status, etc.

Inmates are not authorized to donate blood or blood products.

Inmates may not list themselves as posthumous organ donors while incarcerated.

Any exception to the above will be considered by the Medical Director on a case by case basis.

39. INMATES AS RECIPIENTS OF ORGAN TRANSPLANTATION

The Bureau will consider organ transplantation as a treatment option for inmates in accordance with the following procedures:

When the CD at an institution determines it is medically necessary to evaluate an inmate's suitability for an organ transplant, he or she will initiate an organ transplant laboratory/ specialist consultant work-up at the institution.

When a specialist determines an inmate may be a potential candidate for organ transplantation and the Clinical Director recommends that further evaluation is medically appropriate; the inmate will be **evaluated** at an appropriate facility such as a transplant center in the vicinity of either the institution or a Bureau MRC.

If an organ transplant center considers an inmate suitable for a transplant, the institution CD will compile all pertinent medical/surgical/case management/mental health/social work information and forward to the Medical Director for consideration.

If the Medical Director determines that an organ transplant is medically indicated, the inmate will be approved for surgery at an appropriate transplant center in accordance with Bureau policy, transplant center regulations, and state and federal laws.

The Bureau will pay medical care and hospitalization costs associated with organ donors.

These expenses are limited specifically to those costs directly related to the transplant procedure itself.

40. PHYSICAL THERAPY/REHABILITATION SERVICES

Bureau-staffed Rehabilitation Services are ordinarily limited to medically designated inmates at MRCs. Each MRC will have a written local policy outlining at least the following topics:

- Scope of services.
- Referral process from health care providers.
- Referral process to health care providers.
- Use of inmate workers in the department.
- Quality Improvement Program.
- Preventive maintenance of equipment.
- Infection control.
- Procurement of durable medical equipment and supplies.
- Safety/security.

Inmates at non-MRCs occasionally require assessment and treatment by a physical therapist. CDs should consider telephone or tele-health consultation with an MRC therapist to help design a specific program for a specific inmate. Alternatively, therapists in the local community may be used intermittently.

Inmates requiring extended, formal physical therapy should be referred to an MRC via a Medical /Surgical and Psychiatric Referral Request form (BP-A0770).

Prior to submitting the BP-A0770, the CD will discuss the inmate's diagnosis and current condition with an MRC therapist, to determine if the transfer is appropriate, and if the inmate can or will benefit from physical therapy or other modalities.

41. SOCIAL WORK SERVICES

Currently, Social Work services are available only at MRCs. Guidance from the Medical Director will be provided in relation to expanding the role of social workers to serve non-MRC inmates.

Each MRC will have a written local policy for Social Work Services, outlining the following topics:

- Scope of services.
- Referral process from health care providers.
- Referral process to health care providers.
- Quality Improvement Program.
- Transitional care/release planning, end-of-life care, and advance directives.

42. SEXUAL ASSAULT PREVENTION AND INTERVENTION

a. **Prevention**. General training requirements for staff will be in accordance with the Program Statement **Sexually Abusive Behavior Prevention and Intervention Program**.

Medical staff will refer to Psychology Services all inmates who have been identified as victims of:

- Sexually aggressive behavior.
- Sexual pressure.
- Sexual harassment.
- Sexual assault.

b. **Intervention.** When an inmate reports being sexually assaulted, medical staff will document the inmate's complaint and subjective/objective findings fully on the Inmate Injury Assessment and Followup form (BP-A0362) and notify institution authorities regarding this complaint immediately. The plan for further evaluation and treatment will also be included on the BP-A0362.

In order not to compromise medical evidence on an inmate who reports a recent sexual assault, it is recommended that the inmate be transported to a community facility/rape crisis center that is equipped (in accordance with local laws) to evaluate and treat sexual assault victims. (Refer to the Program Statement **Sexually Abusive Behavior Prevention and Intervention Program**.)

Institutions may use on-call contracted clinical care staff to provide sexual abuse/assault treatment. These clinical care providers would report to the institution via a contractual arrangement when institution authorities call.

Only in institutions where extreme security concerns exist may in-house physicians be used to provide treatment, examination, and forensic evidence gathering to inmates who report sexual abuse/assault.

Annually, these staff must be specifically trained and demonstrate knowledge and skills in sexual abuse/ assault treatment and forensic evidence gathering.

An individual who has recognized expertise in this field (e.g. sexual abuse/assault treatment staff in a community-based hospital emergency department or community-based rape crisis center) must perform this training.

The Clinical Director will ensure (whether treatment has been provided in-house or in the community) that appropriate infectious disease testing, medical examination, and medical physical evidence collection has been conducted and the results of all examinations/ evaluations have been provided to institution SIS staff.

Specific procedures for evaluating and treating victims of sexual abuse/assault will be included in the Institution Supplement for the Sexually Abusive Behavior Prevention and Intervention Program.

43. EXAMINATION BY PERSONAL PHYSICIAN

Ordinarily, inmates are not permitted to use their own physicians or other providers, whether on a reimbursable or non-reimbursable basis, or whether there was a prior relationship between the inmate and the provider.

There is no prohibition if a provider, ordinarily used or specially engaged by the Bureau, happens to have been a prior health care provider to the inmate; however, this is discouraged.

Discretion may be exercised to permit a private physician visit only when a private physician was treating an inmate prior to incarceration. Should an inmate request to be examined by a specific physician during incarceration, the Warden, upon consultation with the Regional Director and Medical Director, may permit such a visit **for examination only** at the inmate's expense.

Such action may not be routine and it is anticipated that it will be infrequent.

Should permission be granted for such a visit, the Warden will ensure reasonable time and space for the examination are provided.

The inmate will execute an Authorization for Release of Medical Information (BP-A0621). The visiting physician will be licensed by the state in which the institution is located. The Health Services Administrator, or designee, will verify the license in accordance with the Program Statement **Credentialing, Privileging, and Practice Agreements**.

The staff physician will meet with the visiting physician and freely discuss the case and be present during the exam.

The staff physician will have authority from the Warden to terminate the examination if inappropriate activities are witnessed.

While the visiting physician will not be provided the inmate's health record for unsupervised perusal (but may review it under supervision), the staff physician should freely discuss the record, particularly in response to the visiting physician's questions.

If the personal physician requests copies of the inmate's health record, this request will be managed in accordance with the Freedom of Information Act (FOIA) as described in Program Statement on Health Information Management.

The visiting physician will provide a written report. The staff physician should review any recommendations the visiting physician makes and accept any documents that the physician may present, but is under **no** obligation to carry out the visitor's recommendations.

If the private physician's recommendations are not followed, an entry will be made in the inmate's health record to explain this decision.

Any documents the visiting physician provided will be filed properly in the health record. (Section 5, Civilian Records Divider)

The staff physician will document the visit in the progress notes.

44. INVOLUNTARY MEDICAL TREATMENT/REFUSAL OF TREATMENT BY INMATES

See the Program Statement **Psychiatric Services** for guidance regarding involuntary medication and/or hospitalization for psychiatric illness.

Any refusal of recommended or offered treatment or a diagnostic procedure will be documented in the inmate health record. The inmate will be asked to sign a Medical Treatment Refusal form (BP-A0358).

If the inmate refuses to sign, two staff witnesses will attest and sign to the fact that the consequences of refusing the proposed treatment or procedure were explained to the inmate in a language he/she understood.

As a general rule, medical and dental treatment including medication is given only when the inmate consents. Exceptions may be made when a Bureau or contract physician determines:

- There is a danger to life or of serious permanent injury to the inmate.
- The inmate poses a risk to others by refusing treatment (e.g. infectious tuberculosis).
- There is a court order for evaluation or treatment to be provided.

Diagnostic procedures relating to potential communicable disease may be mandatory for the protection of the inmate or other inmates and staff. (Refer to the Program Statement **Infectious Disease Management**.) These procedures include, but are not limited to:

- Tuberculin screening tests.
- Chest x-rays.
- Blood specimens for hepatitis or HIV (post-exposure incident).

Refusal of such procedures will require an incident report. The Clinical Director will determine whether medical isolation is clinically indicated.

An inmate may revoke a signed BP-A0358 if he/she later decides to follow the health care providers' medical advice. If the proposed treatment's potential outcome has been compromised by the delay associated with the inmate's refusal, this will be communicated to the inmate and

documented thoroughly in the inmate's health record (e.g., delay in accepting recommended treatment for cancer may affect the treatment's success.)

The CD and/or HSA should consult with Bureau legal staff whenever questions arise regarding involuntary medical treatment not addressed in this Program Statement.

45. EXPERIMENTATION AND PHARMACEUTICAL TESTING

Inmates in the custody of the Federal Bureau of Prisons will not be used as subjects for any non-therapeutic medical experimentation.

This does not preclude the use of approved clinical trials that may be warranted for a specific inmate's diagnosis or treatment when recommended by the CD and approved by the Medical Director.

Such measures must have the inmate's prior written consent and must be conducted under conditions approved by the Department of Health and Human Services.

Research regarding disease prevalence, response to accepted therapeutic interventions, etc., can be performed under protocols meeting the requirements of the Program Statement **Research**.

46. RADIOLOGY SERVICES

Radiology services provided or made available by the Bureau will be designed to meet the needs of patients in accordance with professional practices and legal requirements. Appropriate radiographic or fluoroscopic diagnostic and treatment services will be provided or made available.

a. **Staffing.** A registered radiologic technologist or a radiologic technician is required as part of each institution's clinical staff. Bureau staff with documentation of radiologic technician training obtained from an accredited community source may also be utilized.

The registered radiologic technologist will be a graduate of a program in radiologic technology, approved by the Council on Medical Education of the American Medical Association.

b. **Procedure Manual.** Each institution will have written procedures which cover:

- Identification of the current director of radiology.
- Scheduling.
- Examinations performed.

- Administration of diagnostic materials.
- Infection control procedures.
- Management of isolation patients.
- Management of emergency patients.
- Care of the critically ill.
- Preventive maintenance.
- Radiation safety/safety precautions.
- Disaster plans.
- Required records and reports.
- Preparation of patients.
- Calibration and safe use of equipment.
- Inspection of x-ray safety equipment for defects.
- Radiation exposure precautions.
- Precious metal recovery.

c. **Record keeping.** A daily x-ray log, in a bound ledger or in electronic form, will be established in the x-ray department. The log will contain:

- Register number.
- Patient name.
- Type of study.
- Number of exposures.
- Name of person performing study.
- X-ray exposure technique.
- Reason for and number of retakes, if applicable.
- Date film was sent for interpretation.
- Date report returned.
- Date film was returned.

X-ray films will be identified with a name imprint system. Imprint identification of radiographic films is the only method permitted. Information required includes:

- Institution name.
- Patient name.
- Register number.
- Date of birth.
- Sex.
- Date of exam.

d. **Privacy.** A concerted effort will be made to ensure patient privacy at all times, particularly for undressing and dressing, examination, waiting in the department, and evacuation of contrast media.

The changing area and patient bathroom will connect directly with the examination room when physical plant and resources permit.

e. **Ordering Radiographic Examinations.** Diagnostic radiology services will be performed only upon the written request of a physician, dentist, or MLP.

A Radiographic Report (SF-519A) will be used for ordering radiographic exams. (Forms other than the standard form may be used, if they are the designated form of a contractual, non-Bureau radiology service.) All forms must contain:

- Patient's full name and register number.
- Age and sex.
- Examination requested.
- Name of requesting provider.
- Reason for the examination.
- Inpatient or outpatient status (if applicable).
- Date of requested examination.
- Name of the institution.

f. **Radioactive Sources/Radioisotopes.** Use of any radioactive sources or radioisotopes (MRCs only) will be limited to physicians who have been granted privileges for radioactive sources.

Orders for using radioactive sources or radioisotopes will be written and accompanied by:

- A concise statement of reason for use.
- Total dosage.
- Incremental dosages in standard measurements (cGy or Rads).
- Number of treatments.

g. **Evaluation/Interpretation of Radiographic Film.** After the examination is completed, the date of the exam will be written on the request form.

The ordering clinician will review all STAT requests on the same date as ordered.

Ideally, films should be reviewed (a "wet read") prior to sending the films to a radiologist for interpretation to look for abnormalities such as active TB or fractures which require immediate attention.

This review should be performed within two working days of the examination, so as not to delay the final interpretation.

Films will then be sent for a radiologist's interpretation.

A radiologist will interpret all x-ray examinations; the interpretations will be recorded on the x-ray report form, or on a report form the radiology group uses.

The radiologist who interpreted the film must sign (authenticate) all completed x-ray reports.

h. **Distribution of Reports.** Authenticated, dated reports of all examinations performed will be filed in the inmate's health record.

Completed radiographic reports will be reviewed within two working days, dated, and initialed by the CD prior to distribution and filing.

The reviewing physician must ensure that timely, appropriate follow-up actions are initiated on all abnormal findings, and that any actions taken are documented in the Progress Notes of the inmate's health record.

The original copy of the completed report will be filed in the inmate's health record.

The second copy will be distributed to the requesting clinician.

The third copy will be filed in the inmate's x-ray film envelope.

i. **Filing/Transfer/Retention of Radiographic Files.** Radiographic films on inmates will be filed in the terminal digit format, the same format as for inmate health records.

Each film envelope will contain the inmate's name and register number, with a chronological record of the dates and studies performed.

Radiographic films of inmates being transferred to other Federal institutions will be mailed to the receiving institution within five working days of when the inmate is transferred. All available x-rays will accompany the inmate's health record at the time of transfer to an MRC.

Files on inmates released from Federal custody will be placed in an inactive file. The terminal digit system will be used on inactive files, and they will be separated by year.

Inactive files will be maintained in a separate secure area and kept for five years. During the sixth year, they will be transferred to the Defense Logistics Agency for silver recovery and destruction.

j. **Safety.** Signs will be posted on the door to the X-ray Suite and prominently inside the department, instructing individuals to notify the technician if they are pregnant.

When diagnostic agents are administered, safety precautions will include provision for an emergency drug tray, oxygen, airways, and the capability to administer intravenous support.

Appropriate safety equipment will be used for all examinations. Leaded gloves, aprons, and gonadal shields will be visually inspected by staff and films of the shields will be taken at least twice a year for defects.

The films will be sent to the radiologist for interpretation.

Documentation must include a signed report from the radiologist.

Fluoroscopy may also be used to inspect x-ray safety equipment, with signed documentation by a radiologist.

Precautions will be taken to minimize radiation exposure through appropriate shielding and collimation. All doors must be closed during x-ray procedures. The field will be coned down with a collimator as much as possible.

Exposure switches of equipment must be arranged to prevent its operation from outside the shielded area.

The person performing portable x-ray procedures, as well as anyone assisting, will wear a lead apron. Lead gloves will be provided if manual support of position for x-ray is necessary.

All unnecessary personnel will be removed from the immediate area, and the technician performing the procedure will stand as far away as possible from the x-ray tube when making an exposure.

Proper shielding of radiation sources will be maintained. Periodic inspection and evaluation of radiation sources, including calibration of equipment, will comply with Federal, state, and local laws and regulations.

OSHA and FDA regulations regarding the handling, removal, and storage of any radioactive material will be followed.

k. **Radiation Monitoring.** All personnel who use or work in close proximity to radiological equipment will wear a film badge while on duty to monitor cumulative radiation exposure. Individuals will ensure that their badges are not subjected to unnecessary exposure or left in the x-ray room.

Quarterly reports of cumulative exposure will be maintained by the HSA and reviewed and initialed by the CD.

All reports of high exposure or overexposure will be investigated to determine the cause.

FDA recommendations will be followed.

l. **FDA Radiation Survey.** The FDA requires surveys of radiographic equipment at HSUs every two years. The HSA, in consultation with the RHSA, will take corrective action and prepare a response to the report. The HSA will maintain a copy of the report and the corrective action taken if appropriate.

m. **Use of X-ray for Body Searches.** This requires an order from the Warden with the Regional Director's approval. Refer to the Program Statement **Searches of Housing Units, Inmates, and Inmate Work Areas**.

n. **Preventive Maintenance.** All HSUs will establish a preventive maintenance program to be conducted by qualified staff (i.e., a certified biomedical staff member) or establish service contracts for repair and preventive maintenance of radiographic equipment.

Manufacturer's recommendations will be followed when establishing preventive maintenance procedures.

Infection control procedures will be followed after each inmate contact with a cassette. This entails wiping the cassette with an approved cleaning solution (check manufacturer's recommendations).

The x-ray table top must be wiped down with a disinfectant solution after each patient use.

o. **Precious Metal Recovery Program.** It is DOJ policy that, unless exempted by the Assistant Attorney General for Administration or designee, a silver recovery program will be implemented at each Bureau location using precious metal-bearing waste.

Each institution is required to comply with the support agreement between the Department of Defense (DOD) and DOJ Number SC 4400-88154-804, May 1986, and the Program Statement **Property Management Manual**.

Written procedures will be established at each institution to recover precious metals from scrap and waste film. Examples of precious metal-bearing waste include photographic fixing (hypo) solution, photographic and x-ray film, silver alloys, dental scrap, batteries, and electronic parts.

Scrap film is film damaged in processing or purged from the medical files; it will be kept until sufficient quantities are available to warrant silver recovery.

Institutions with automatic film processors will have silver recovery units attached to the processor.

Institutions using a manual, tank-type processing system will save all hypo solution.

47. **MISCELLANEOUS**

a. **Medical Duty Restrictions/Convalescence.** Medical Duty Status restrictions must be consistent with the inmate's medical and/or mental health condition. Refer to SMD/MDS Technical Reference Manual for the list of restrictions which are available in SENTRY.

Medical Idle. Maximum of three calendar days for recuperation from an acute illness or injury. The inmate is restricted to his/her quarters except for meals, religious services, and medical call-outs or pill lines.

Medical Convalescence. Maximum of 30 calendar days for extended recuperation from an illness, injury, or surgery. Convalescence is specifically indicated to facilitate recuperation by

not subjecting the inmate to the rigors of his/her job assignment, or to minimize the risk of injury to the inmate, other inmates, or staff at the work site due to the inmate's medical condition.

Inmates on convalescent status may attend other programs including education classes, drug awareness programs, etc. Restrictions on recreational activities may be written on a case-by-case basis. (For example, an inmate who is rehabilitating from orthopedic surgery may need access to the recreation facilities to walk, or to do specific exercises prescribed by their health care providers.)

b. **Inmate Injury Assessment and Follow-up (BP-A0362).** An inmate must complete a BP-A0362 form for even the most minor injuries, regardless whether they are related to work, recreation, assault, off-duty time, or occupational illness.

In each case the inmate should be quoted directly as to how the accident or occupational illness occurred.

All injury reports must be reviewed and signed by a physician as soon as possible. Under normal circumstances, this will occur the next working day.

A copy of the form will be forwarded to the Safety Manager.

c. **Medical Footwear.** The Bureau is responsible for providing one pair of safety shoes to each inmate, suitable for their job assignment. The Program Statement **Inmate Personal Property** lists other types of shoes which inmates may bring into the institution, or purchase at their own expense.

Occasionally, custom shoes or orthotic devices may be medically necessary to accommodate a significant foot deformity or to decrease the chance of injury to feet with impaired sensation. For example, an inmate with a diabetic neuropathy may need an extra deep, extra wide toe box in their work shoe in order to minimize irritation.

The Clinical Director must approve all requests for purchase of custom shoes and/or orthotic devices.

Custom shoes or orthotic devices will be purchased through the institution Health Services Cost Center.

d. **Feminine Hygiene Products.** The HSU will provide only medically indicated feminine hygiene products. The institution will stock sanitary napkins.